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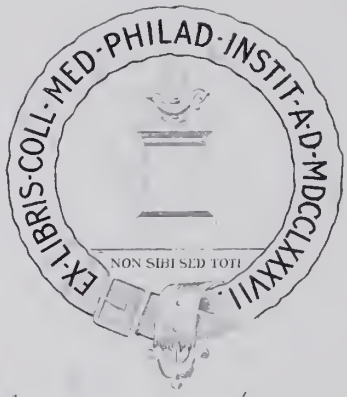

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The Wisconsin Medical Journal

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We, of this country, know that in the immediate future there is much uncertainty, but we take courage and unbounded satisfaction in knowing that the end of the road is clear and that as we approach it we shall find our Nation and the people of all countries, dedicated to the glory of world peace and to the building of an era in which men may live with men as good neighbors.

Gunnar Gundersen

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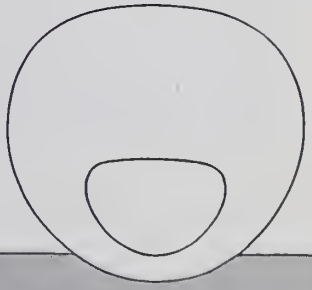

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THE WISCONSIN MEDICAL JOURNAL

Volume 41
Number 1

MADISON, WISCONSIN, JANUARY, 1942

Per Year $3.50
Single Copy 50 Cents

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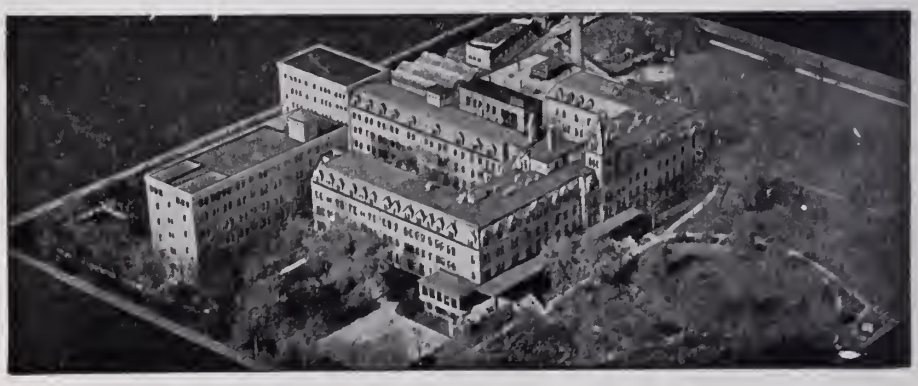
[Entered as second class matter, June 30th, 1903, at the Post Office at Milwaukee, Wis., under Act of Congress March 3rd, 1879. Transferred to Madison, Aug. 1st, 1929.]
"Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized Aug. 7, 1918."



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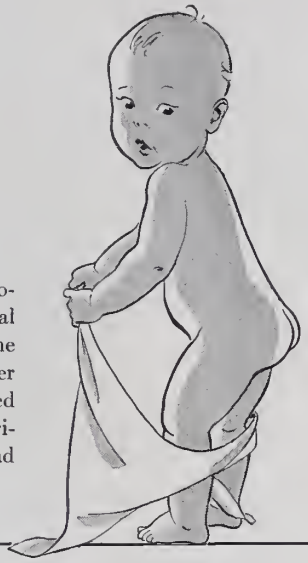

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*Matsuzawa, D; Boyd, L. J.
New York Medical College and
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THE WISCONSIN MEDICAL JOURNAL

VOLUME 41, NO. 1 Copyright, 1942, by The State Medical Society of Wisconsin JANUARY, 1942

A Pyrexia Test: Differentiation of "Functional" Fever From That of Infectious Origin

By MAX J. FOX, M. D.*
Milwaukee

THE persistence of a mild fever in a child after apparent recovery from an infectious disease is occasionally observed. The daily rise in temperature rarely exceeds the normal by more than 1 F., but is of genuine concern to family and physician. Patients are sometimes confined to their beds for weeks, while the physician runs the gamut of diagnostic procedures in search of the cause of the "obscure fever."

Several such cases have been seen in which an organic or infectious basis for the persistent fever was sought by extensive laboratory and clinical tests. X-ray studies, tuberculin tests, blood cultures, agglutination reactions, sedimentation tests, stool examinations, examination of lymphatic structures, search for foci of infection in the paranasal sinuses, teeth, and other areas, and even surgical intervention in some cases, in several instances have all failed to shed any light on the etiology of the fever. In the meantime, the activity of the patient was greatly restricted. In certain of these cases an ultimate diagnosis of "functional" fever was made, and treatment undertaken on the basis of this assumption appeared to be successful. A diagnostic test is here described, and five cases are presented.

The Pyrexia Test

The patient is first given a series of four ~~3/5~~ gr. doses of one of the coal tar antipyretics, at four-hour intervals, and the temperature recorded every two hours. The usual response is a fall in temperature within two hours after each dose, and a subsequent rise by the end of four hours. The patient is then allowed a period of twenty-four hours for the elimination of the antipyretic drug, and is then given a dose of 1/6 to 1/8 gr. of morphine sulfate hypodermically. The temperature is recorded every two hours for the following twenty-four hours. If the temperature is found to remain normal or subnormal for a period of ten to eighteen hours, it is assumed that the fever was not the result of a focal infection, and the patient is encouraged to leave his bed and resume his normal activity. After a suitable period of adjustment at home, he is allowed to return to school and to his normal social contacts. If the patient presents a history of idiosyncrasy to morphine, dilaudid or a barbiturate may be used for the test.

Report of Cases

Case 1 (male, 8 years of age).—This child suffered from a hemolytic streptococcus infection of the throat. Following a sudden onset, there were chills, headache, and dysphagia. The nasopharynx was injected, and the tonsils were greatly enlarged and covered by a purulent exudate. Under symptomatic and empirical treatment, the infection subsided satisfactorily. From the end of the third week, and for five weeks thereafter, there was an afternoon elevation of temperature from 98.8 to 99.4 F. An otolaryngologist called in consultation was unable to find residual infection. Chest x-rays, tuberculin test, and blood studies were negative. The pyrexia test was done, and found positive. The patient was then permitted up, and returned to school two weeks later with a normal temperature.

Case 2 (female, 11 years of age).—In November, 1940, this patient had an upper respiratory tract infection with acute onset. This infection was followed by a non-exudative bronchitis, with a high afternoon fever. Two weeks following the onset of bronchitis, the patient developed a productive

* Medical director, South View Hospital; Milwaukee Health Department.

+ See Correction, p. 262

cough. By the end of the fourth week, the cough and severe fever had subsided. The afternoon temperature remained about 99.3 F., however, and at the end of eight weeks the parents requested consultation. Hospitalization was advised, and the patient was transferred from her home to the hospital. Chest x-rays, tuberculin test, sedimentation and agglutination tests, blood cultures, catheterized urine examination and culture, were all negative. The pyrexia test was done, and found positive. When the patient had been out of bed a few days, the afternoon temperature was normal, and she returned to school. There have been no untoward developments to the present date.

Case 3 (male, 4 years of age).—This patient had an acute upper respiratory tract infection early in 1939, and following this was in bed intermittently for a year. In January, 1940, the patient developed an otitis media, and his ear discharged for several months. In May, 1940, a tonsillectomy and adenoidectomy were done, and early in July the patient developed a streptococcic sore throat of three weeks duration, with fever and anorexia, but without any rash. Early in August, 1940, there was a sudden development of migratory joint pains, with heat, swelling, redness and disability, and as a case of acute rheumatic fever the patient was kept at absolute bed rest and given salicylates. The symptoms disappeared within four weeks after onset, but he continued to show an afternoon rise in temperature to 99.8 F. Physical examination with special attention to the joints and the heart, blood examination, sedimentation rate, and sinus transillumination, were all negative. When the fever had persisted for four more weeks, a modified pyrexia test (using luminal instead of morphine) was done, and was found positive. The patient was ordered up, and daily determinations of temperature one hour after the afternoon nap were made. The temperature curve thereupon became normal, and remained so. He quickly regained strength, and is still gaining in weight. There has been no evidence of heart damage, and no recurrent involvement of the joints.

Case 4 (male, 14 years of age).—In December, 1938, this patient developed a severe sore throat from which hemolytic streptococci were cultivated. After three weeks of convalescence, the throat findings were negative and throat cultures were negative for hemolytic streptococci; however, the mid-afternoon temperature continued to reach 99.4 F. An otolaryngologist was unable to find any focus of infection. Hospitalization was recommended. Before considering hospitalization, however, the pyrexia test was done, and was found positive. Four days after the test, the child was returned to school. There were no ill effects, and the child at present is in good health.

Case 5 (female, 12 years of age).—In November, 1939, this patient suffered from an acute upper respiratory tract infection, complicated by invasion of the nose and throat by hemolytic streptococci at the end of the first week of the disease. Twenty cc. of convalescent scarlet fever antiserum and sulfanilamide were given. The fever was sharply reduced, but a mid-afternoon elevation to about 99.5 F. persisted. Examination by otolaryngologists was negative except for a darkened antrum on one side, and the opinion of the consultants was that a residual sinus infection persisted. Treatment of the sinus infection brought no change in the appearance by transillumination. Roentgenography of chest, and blood studies were negative. At the end of the fourth week, a pyrexia test was done, and was found positive. The child was permitted to be up and around, without ill effect, and at the present time is well.

Discussion

Certain influences of psychic and mental states upon physiological reactions are commonly recognized. Thus we often associate vasomotor instability, rapid or readily accelerated pulse, spastic constipation, anorexia, enuresis, and habit spasms, with mental or emotional conflict. It is less commonly recognized, however, that elevation of temperature may represent a comparable response.

I have often observed the lability of children's temperature. Frequently in the home a child shows a temperature of 100 or 101 F., but half an hour later, after transportation by ambulance to the hospital, registers a rise to 103 F. or more. Inexperienced personnel may be deceived in estimating the severity of the infection at admission. When the patient has become adjusted to the hospital environment, the temperature falls to its previous level, and may not again rise beyond it.

This peculiarity has been commented upon by several writers. French[1] states that "the heat-regulating mechanism, like other nerve functions, takes time for its stable and complete development, and it is apt to be upset in children by causes that would not produce pyrexia in adult; hence transient irregular or recurrent rises of temperature in a child may often be of but little significance . . . Some patients run a low form of continued pyrexia without any apparent reason for it and without any apparent ill health; they may contend that they are absolutely well and fit for games

and everything, yet the continued slight pyrexia keeps one anxious lest there be latent disease, particularly tuberculosis or insidious infectious endocarditis." Pfaundler and Schlossman[2] state that, "It is both interesting and important that the autonomic pathways concerned in regulation of body temperature may be extremely labile in nervous children . . . There is a tendency to elevation of temperature which is not uncommonly found in children with vasomotor hyperirritability, and which may persist for weeks or months, independently of any organic disease or infection. It may, however, often directly follow some infection, persisting as an afternoon or evening pyrexia." Griffith and Mitchell make a similar statement[3] concerning this phenomenon: "In some children, especially those of a highly neurotic nature, the temperature is persistently elevated during at least a part of the day, even with the child at rest, without this possessing any significance."

The rationale of this test is simple. Morphine depresses the central nervous system, beginning at the cortical levels. In "functional fevers," morphine induces mental and muscular relaxation, and reduces the exaggerated heat production. Under repeated tests and observations, no case established as fever of infectious origin has been brought to normal by the administration of morphine or other opiates. The barbiturates are no more effective in reducing fever of infectious origin than are the opiates, and their use in the pyrexia test is similar. The coal tar antipyretics, on the other hand, depress fevers of both infectious and "functional" origin.

Summary and Conclusions

1. Persistent, low-grade fever occasionally follows apparent convalescence from an infectious disease. Five cases are described in which this fever was abolished by administration of sedatives, and were apparently without infectious basis.

2. A pyrexia test for the differentiation of such "functional" fever from that of infections origin is described.

3. It is recommended that in all cases of fever prolonged two weeks or more beyond the convalescent period, the pyrexia test should be tried as a first step in the investigation of the "obscure fever." Patients in whom the fever appears to be "functional" may be allowed to resume normal activities without harm.

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(Further references on p. 262-4.)

Laryngotracheobronchitis

By WILSON J. TROUP, M. D., and DAVID F. WEAVER, M. D.
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MANY excellent articles on laryngotracheobronchitis by Richards,[1] Gittins,[2] Baum,[3] Jackson,[4] Holinger,[5] Brennemann,[6] and many others have been published in the past several years. Despite the increasing number of cases reported each year, there are still many men who are entirely ignorant of this disease entity, and there are many others who, though aware of the features of the disease, believe that treatment is of no avail. We were surprised to learn how few men in our community were familiar with this disease, and to learn that others throughout the country found this to be true, also. Even among nose and throat specialists, there are many who lack specific knowledge on the subject.

It is not the purpose of this paper to present anything particularly new, but to call attention to the salient features of this

disease, and to stress the importance of cooperation by all concerned in its treatment.

Laryngotracheobronchitis is now recognized as a definite clinical entity, which is characterized by an intense inflammation of the larynx, trachea, and bronchi. The products of inflammation have a strange tendency to form sticky, gum-like exudates in the air passages, which wholly or partially obstruct them and hence are chiefly responsible for the serious nature of this malady.

Etiology

This disease occurs in its typical fulminating form most often in children under 2 years of age, and it is in children of this age group that the mortality rate is so high. It attacks older children, but it is usually not so severe or fulminating as in the younger group. Very young children become more easily exhausted, as their bronchi are smaller, and hence swelling of the mucosa, together with the gummy exudate, is more apt to cause serious obstruction. These cases may be associated with an epidemic of upper respiratory infection or may occur as sporadic cases. They may begin with a slight head cold or may begin with a primary laryngeal involvement. The hemolytic streptococcus, the Staphylococcus, pneumococcus, and the influenza bacillus have been found in these cases, but the hemolytic streptococcus is more often found by itself than any of the others.

Pathology

The mucosa and submucosa of the trachea and bronchi are involved by the inflammatory process, extending downward from the larynx. The submucosa in the subglottic region is composed of very loose, areolar tissue, and hence becomes more swollen than that of the trachea and bronchi. It is this subglottic swelling that is chiefly responsible for the laryngeal obstruction. The gummy, tenacious exudate resulting from the intense inflammation is composed of mucus, necrotic degenerated epithelial cells, fibrin, and acute inflammatory cells.[6] It is this exudate, together with the mucosal swelling, which is most troublesome in causing obstruction of the trachea and bronchi. In the favorable cases, the sticky, gummy exudate gradually becomes more liquid after several days, and finally, as healing takes place, disappears altogether. Atelectasis may result from a complete plugging of a bronchus, emphysema may be either compensatory or result from an incomplete obstruction, and pneumothorax occurs in some cases, presumably resulting from the rupture of an emphysematous bleb. At autopsy, later stages in the inflammatory process have been noticed in which the submucosal glands become degenerated, the mucosa necrotic or destroyed, and a fibrinous or fibrinopurulent exudate present, grossly giving a dry glazed appearance to the trachea and bronchi.[6] Also, bronchopneumonia is often a terminal complication found at autopsy.

Diagnosis

The results of our treatment of laryngotracheobronchitis depend a great deal on an early diagnosis, and hence the internists and pediatricians should acquaint themselves with all phases of the disease, as they are the ones who usually see these cases first.

The onset is fairly typical, in which the story is that the child was perfectly well except perhaps for a slight head cold, when a croupy, barking cough with some hoarseness developed. These cases are usually observed at home until dyspnea and stridor become so marked that hospitalization is advised. At the time they are first seen by the endoscopist, the laryngeal obstruction is quite manifest, as evidenced by marked dyspnea, stridor, and retraction of the suprasternal, supraclavicular, and epigastric spaces. As the obstruction increases, the child becomes more apprehensive, the pulse rate and temperature rise, cyanosis develops, and it becomes evident that an airway must be established at once if the stage of utter exhaustion and death is to be avoided. The diagnosis is definitely established by the physical and endoscopic examinations which, of course, vary as to the stage and the amount of involvement.

The physical findings in mild cases may be identical with those of ordinary croup, with no definite chest findings present. In

the later stages or in the fulminating cases presenting the picture of respiratory and vascular decompensation, the signs are of great aid. Often a limitation of excursion on one side due to partial or complete block of the bronchus may be seen. Auscultation nearly always reveals a marked wheeze, more pronounced on the obstructed side, with a suppression of breath sounds over the affected area. There are many coarse rales throughout both lung fields, but usually no significant rales, except in a terminal pneumonia. Following aspiration by bronchoscopy or by catheter, the above signs usually disappear completely. Very often cough reflex is completely absent. Bacteriologic examinations, both smears and cultures, should be taken to rule out diphtheria. Roentgen-ray examination often reveals an atelectasis or emphysema of one lung with shifting of the mediastinum. Foreign body and streptococcic laryngitis must be ruled out by direct examination.

The endoscopic findings are quite characteristic, and have been ably described by Baum,[3] Jackson,[4] Holinger,[5] and others. The supraglottic structures may be red, swollen, and inflamed, and the vocal cords may show some redness with yellowish gray crusts adhering to them, but in many cases show little, if any, involvement. It is the inflamed swelling of the subglottic region which is noted particularly, and is seen to bulge toward the median line in two folds just below the cords, leaving only a small slit posteriorly for an airway. A purulent exudate is seen as the trachea is entered, and thick tenacious exudate may be seen adhering to the walls or plugging the lumen of the bronchi. The mucosa of the trachea and bronchi is a deep red, and thickened by the inflammatory swelling. There is no ulceration of the mucosa, no bleeding surface, and no membrane as in diphtheria.[4] In fatal cases, the red mucosa is replaced by a gray surface on which is a grayish, thick exudate, giving a dry, glazed appearance to the trachea and bronchi.

Treatment

There are mild cases of this disease which will respond to adequate fluid intake, steam inhalations, and oxygen therapy; however, there are others in which, by physical and endoscopic examinations, it is evident that an airway must be established if the child is to survive. It is to these fulminating cases of laryngotracheobronchitis that the following described treatment applies.

A team of at least four people is necessary for proper treatment, and includes a trained endoscopist, a pediatrician or internist, and two or three nurses, one of whom is watching the patient every minute of the day. Hospitals in smaller communities seldom have interns, so it means that the attending doctors must spend considerable time with these children. The nurses in charge should be competent, and should be instructed in every detail of the treatment, as the outcome of these cases often depends on their judgment and cooperation.

To establish an adequate airway, a tracheotomy is done at the time of the endoscopic examination, and is often done over a bronchoscope or over a Mosher lifesaving tube. It is now generally agreed that a tracheotomy is preferred to intubation as removal of crusts and plugs obstructing the trachea and bronchi are more easily removed through the tracheotomy opening, and, too, in many of these patients that are intubated first a tracheotomy is often necessary later.

Following the tracheotomy, the child usually is immediately relieved, and often falls asleep for several hours, only to be awakened with a return of obstructive signs. Our efforts following tracheotomy are directed toward lessening of the formation of these plugs and crusts in the trachea and bronchi, to their removal when causing obstruction, and also general measures to keep up fluid and food intake.

Our best means to lessen or prevent the formation of obstructive crusts is to keep the air in the room hypersaturated with moisture at all times. In order to insure adequate moisture in the room without the oppressive heat that we get when a steam inhalator is used, an electric humidifier is very satisfactory. The humidifier we have been using furnishes so much moisture that it is necessary to mop up the floor at intervals. The

greatest trouble with using an oxygen tent has been that the air in it becomes too dry, and hence many physicians administer oxygen direct to the tracheotomy opening by means of a funnel. Davison[7] reported the use of an oxygen tent to which a humidifier had been attached, and this proved most satisfactory, as he was able to maintain moisture in the tent without too much heat. In 1939 he had only one death in 10 cases, none of which required bronchoscopy after tracheotomy, and he attributes his good results to the use of this humidified oxygen tent.

Liquefying agents, such as normal saline, sodium bicarbonate, and weak solutions of epinephrine are of great aid in the removal of the exudates. Several drops of the solution are instilled into the trachea through the tracheal opening, and the child is turned slightly toward the obstructed side so that the fluid may more easily reach that bronchus. Several minutes after the instillation of the fluid, suction is done through a small, rubber catheter. In using the catheter for suction, it is best to introduce it before the suction apparatus is turned on and to turn the child's neck and tracheotomy tube so that the obstructed bronchus can be reached more easily.

The fluid intake is kept up by mouth preferably, but fluid may be given intravenously or subcutaneously if necessary. Unnecessary laboratory work should not be done, as the child should be allowed to rest as much as possible. A nurse can be of great assistance in these cases, as she is responsible for the maintenance of moisture in the room, she instills liquefying solutions, uses suction at intervals, and most of all notifies the doctor when any sudden change in the child's condition takes place.

Providing the above procedures are carried out diligently, the formation of obstructing crusts is kept at a minimum, and bronchoscopic removal of the crusts through the tracheotomy opening is seldom necessary. There are many cases in which bronchoscopy was not necessary at all after the tracheotomy was done.

Drugs are used very little in treating this disease, particularly morphine and atropine, as the one tends to abolish the cough reflex and the other decreases the secretions. Sulfanilamide was used with good results by Davison[7] in his series of 17 cases, and is favored by many men in treatment of those cases in which the hemolytic streptococcus seemed to be the causative organism. In the cases in which pneumococci are found in pure culture, sulfapyridine should be used.

The following is a report of a typical case of laryngotracheobronchitis in a child 4 years of age.

Case Report

A boy, aged 4, was sent into the hospital January 19, 1940, by his physician, W. P. Tippet, Green Bay, because of increasing difficulty in breathing. His history revealed that he had had a mild upper respiratory infection with a croupy cough and a low-grade fever for three days prior to admission. The day before admission a respiratory stridor began which rapidly increased in severity until at the time of admission definite signs of respiratory failure were apparent. His temperature rose to 103 F., his respirations became more shallow, and he was having more difficulty in breathing.

Physical examination shortly after admission revealed a critically ill child with a temperature of 103 F., respirations 50, and pulse rate 140 per minute. His pulse was weak, and at times almost imperceptible. His respirations were shallow, labored, and stridulous in character. There was marked retraction of the suprasternal notch and infrasternal region, with all of the accessory muscles of respiration brought into play. There was a grayish cyanosis of the skin and mucous membranes, the extremities were cold, and the entire body was covered with a cold perspiration. Examination of his chest revealed a loud inspiratory wheeze of a laryngeal type over both lung fields, and there was also a musical bronchial type wheeze more marked on the right. The breath sounds were diminished to absent over the entire right lung with a relative increase over the left lung. The heart was not displaced. Hyperresonance over the right axillary region of the right upper lobe was thought at the time to be emphysema. Many coarse, moist rales were heard throughout both lung fields.

As the child was in extremis, he was taken immediately to the operating room for tracheotomy. A direct examination of the larynx was made and revealed marked swelling and congestion of the supraglottic region with a purulent exudate exuding from the larynx. Further examination could not be made, as the child stopped breathing, and it was necessary to insert a Mosher lifesaving tube. Following this, the child breathed easier, and a tracheotomy was done with the lifesaving tube in place. Cultures taken

at the time of the tracheotomy revealed hemolytic streptococcus, but no diphtheria bacillus.

Following the tracheotomy, the general condition was much improved, respirations were easy, about 35 per minute, and his color was good. He was placed in an atmosphere super-saturated with moisture kept at a temperature of about 74 degrees. Three hundred fifty cc. of 0.8 per cent sulfanilamide in normal saline were given slowly by hypodermoclysis into the thighs, and following this neoprontosil, 5 cc., was given intramuscularly every five hours. Frequent aspiration of the tracheotomy tube, using a soft 12 French catheter was carried out as often as was necessary, preceded by a few drops of normal saline and 1–10,000 solution epinephrine in order to soften the plugs of secretion. Before using suction, the side of the obstruction was determined by auscultation, thereby enabling us to turn the tracheotomy tube and the child's neck in such a position that the obstructed bronchus could be more easily reached.

On the second day, his temperature rose to 105 F., and he had several severe convulsions. These were controlled by oxygen, therapy, and administration of 50 per cent magnesium sulphate intramuscularly. His condition was somewhat better on the third and fourth days, but it was necessary to use suction at frequent intervals to remove obstructive plugs from the bronchi. On the fourth day, his respiratory rate rose to 50, and a roentgenogram of the chest at that time revealed a 25 per cent pneumothorax on the right side.

From the fifth day on, there was gradual improvement, with less and less frequent aspirations necessary. On the tenth day of his hospital stay, his respirations and temperature were normal, and almost complete absorption of the air in the pleural cavity had taken place. The thick, gummy exudate had changed to a more liquid form, and could be easily aspirated to allow him a free airway most of the time. Decannulation was begun on the thirteenth postoperative day, and completed on the sixteenth day.

Comment

The various clinical features of laryngotracheobronchitis have been brought out in this case report. Although this child was 4 years of age, he presented the findings of severe fulminating involvement. The use of an electric humidifier to furnish moisture was an important factor in aiding this child's recovery after the tracheotomy was done, and cannot be stressed too strongly.

Summary and Conclusions

1. Laryngotracheobronchitis is presented as a clinical entity, and the various features of the disease are described.

2. The mortality rate of this disease is high, but it can be kept at a minimum providing a diagnosis is made and a systematic routine of treatment as outlined here, is followed.

3. A knowledge of the clinical, bronchoscopic, and pathologic aspects of this disease is necessary for proper treatment.

4. A typical fulminating case of laryngotracheobronchitis is presented.

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DISCUSSION

Neal S. Simons, M. D., Whitehall: Dr. Troup has rendered a valuable service in presenting this very practical paper. He has covered the treatment of a typical case so completely and so well that I can only endorse his technique. I know from personal experience that many cases of acute laryngotracheobronchitis in young children go unrecognized and are treated as spasmodic croup, or atypical bronchopneumonia. The usual cough mixtures are administered, various sprays and nose drops are used, and counter irritants are applied to the chest until extreme dyspnea, cyanosis and rapid pulse develop. Years ago, before we understood the pathology in these cases, intubation or tracheotomy was tried as a last resort and as a rule without benefit. Quite a few of these unfortunate children came under my care before I knew anything about endoscopy and the results of my treatment were 100 per cent bad. I believe a similar condition still prevails throughout the country because so few of the pediatricians and general practitioners are acquainted with the pathology of acute laryngotracheobronchitis. Spreading this information is an educational program in which we can help greatly.

All children with symptoms of a mild infection of the upper respiratory tract, followed by cough, hoarseness, increasing stridor, and symptoms of exhaustion should be regarded as possible victims of

this disease. The differential diagnosis is not difficult, especially where physical signs of bronchopneumonia are absent. Laryngeal diphtheria and foreign body must be ruled out if necessary by direct laryngoscopy. Diphtheria producing laryngeal obstruction is now very rare. In more than twenty-five years of practice I have seen only one case which could be confused with laryngotracheobronchitis.

As soon as the diagnosis of acute laryngotracheobronchitis is made, the patient, even though he has a very mild infection, should be hospitalized where a competent endoscopist is constantly available. Throat smears and cultures will indicate which of the sulfanilamide derivatives are to be used, fluids should be pushed, sufficient humidity supplied and postural drainage established. Many of these children, because of exhaustion or the use of sedative cough mixtures, have lost the ability to expel the thick bronchial secretion, and therefore postural drainage is very helpful. Small children do not mind having the foot of the bed elevated and it is easy to maintain the proper position by tying the patient's feet to the foot of the crib. No cough medicines or sedatives should be given, but oxygen is often a great help. If cyanosis develops, a low tracheotomy should be performed immediately and the obstructing material removed through the bronchoscope.

A bronchoscopist is absolutely essential in treating these cases. In no other way can the diagnosis be confirmed and the mechanical obstruction relieved.

Second in importance is the supply of sufficient body fluids and excessive humidity to the air. The cases we treated ten or more years ago required frequent bronchoscopy for clearing the airway after tracheotomy. I recall one boy 18 months old treated in 1928 in whom the bronchoscope had to be passed four times during the first night to remove dried secretions obstructing the bronchi. During the last three years no case of mine has required more than one bronchoscopy after tracheotomy. This improvement is mostly due to the practice of supplying excessive moisture to the room air and pushing body fluids. The bronchial secretions become less tenacious and can be removed by frequent suction.

Third in importance is the specific therapy directed against the offending organism. Sulfanilamide and its derivatives are of great value.

The Pneumoencephalogram in Children

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PNEUMOENCEPHALOGRAPHY was introduced as a diagnostic aid by Dandy in 1918.[1] It was presented as ventriculography and a year later as cerebral pneumography, or, "roentgenography of the brain after the injection of air into the spinal canal."[2] The procedure in its simplest form requires more skill than apparatus. It should be done only by an operator who is thoroughly skilled and experienced in the technique and who is perfectly familiar with the reactions. The operation is absolutely unjustifiable unless the roentgen films are properly made and correctly interpreted. One must be reasonably certain that the child has no greatly increased intracranial pressure and that he has no posterior fossa tumor. The patient must be free of any infection particularly of the respiratory passages. He must not have a cough.

Procedure

The child is given an adequate dose of a sedative such as phenobarbital the night before and again on the morning of the operation. Nothing is given by mouth on the morning of the procedure. The patient is given an anesthetic of vinyl ether by inhalation or of pentothal by intravenous injection. With the patient securely held, a spinal puncture is made under aseptic technique and the pressure measured. Ten cc. of spinal fluid are removed and air is then introduced either by means of a second spinal puncture needle three or four spaces higher in the canal, or by syringe injection to replace the fluid drained. Fifty to 75 cc. of air are introduced to replace a similar amount of fluid removed. The patient is kept in the sitting position and roentgen films are made immediately in all positions. The patient is then returned to bed with his feet elevated and head lowered. He is kept quiet for forty-eight hours.

Indications

The greatest value of the pneumoencephalogram lies in the field of convulsive disorders. Among these it is often difficult to make a differential diagnosis between idio-

pathic epilepsy, the residuals of cerebral birth injury (hemorrhage, edema, anoxemia), chronic encephalitis, the residuals of cerebral trauma, subdural hematoma, and brain tumor. It may also be difficult to determine whether an extreme behavior problem is of psychologic or of organic origin. A pneumoencephalogram will usually reveal any extensive space producing or space distorting lesion, any distortion of the ventricles, a loss of cerebral substance particularly in the cortex, or an obstruction to the free circulation of air in the subarachnoid space.

The residuals of paranatal cerebral injury (occurring during fetal life, during delivery or shortly thereafter) often leave minute or extensive injury which may produce an endless variety of clinical pictures. It seems hardly fair and certainly not good scientific procedure to dismiss a child with a suspicion or a diagnosis of cerebral birth injury without a pneumoencephalogram to establish the diagnosis or to determine the extent of the lesion.

Among the congenital cerebral lesions it is of great value to know the location and extent of brain defect. This is not possible to ascertain by any means except with the pneumoencephalogram. The procedure was first introduced in the study of hydrocephalus and of brain tumor. Dye injections have subordinated the pneumoencephalogram to a lesser diagnostic aid, but there are occasions when one must determine whether the hydrocephalus is of external or of internal origin and whether the cause is a congenital block, an acquired obstruction, an arachnoiditis, or the result of subdural hematoma.

Shapiro and Tosti have demonstrated that infants with spina bifida and meningocele or myelocele show surprising degrees of ventricular dilatation in the face of relatively normal head measurements.[3] This information was previously available only by necropsy studies.[4]

Law reported that encephalography in infants and children led to a more accurate diagnosis and frequently to the detection of an unsuspected intracranial pathologic condition. The pathologic changes demonstrated were notable because of their variance with the physical findings. In 121 pneumoencephalograms, 73.5 per cent gave helpful evidence of intracranial disease.[5]

Every child with recurring convulsions is entitled to the benefit of a pneumoencephalogram before beginning a long course of treatment. Certainly if treatment has been given a fair trial and proves to be ineffective or unsuccessful the patient must be submitted to a pneumoencephalogram in an attempt to verify the diagnosis. The procedure will often provide information which cannot be obtained in any other way.

Eley stated that, "The introduction of encephalography into the study of children suffering from convulsions has resulted in a better understanding of the gross structural changes that may be present in these patients. Many of these cases have shown 'fixed' cerebral lesions as indicated by various degrees of dilatation, distortion, or displacement of the ventricular system, although occasionally unsuspected brain tumors or cysts have been demonstrated which has resulted in the immediate institution of proper therapy, whereas formerly only symptomatic measures would have been employed until such clinical manifestations developed that would have directed attention to the possibility of a cerebral neoplasm. Furthermore, encephalography has shown the futility of either surgical or medical treatment in those cases with widespread cerebral atrophy that may occur as a result of developmental defects, trauma, or infection." Eley found that if he selected epileptic patients with normal encephalograms, 90 per cent responded favorably to the ketogenic diet.[6] Penfield and Keith have presented a group of so-called epileptic patients in whom pneumoencephalograms helped to establish focal epileptogenic lesions the result of birth and infantile injuries. The roentgen findings indicated that surgical treatment might relieve the patients.[7]

I shall present a few cases in which the pneumoencephalogram gave considerable aid in the diagnosis and in prognosis.

Fig. 1. Case 4. Lateral ventricles and posterior horns, also third ventricle and air over sulci on right. No air in subarachnoid space on left side.

Fig. 2. Case 5. Well dilated and distorted lateral and third ventricles.

Fig. 3. Case 5. Dilated ventricles particularly fourth.

Fig. 4. Case 5. Same as Fig. 3.

Case Reports

Case 1.—E. F., 7 weeks of age, began to have generalized convulsions which terminated on the right side. The seizures stopped after spinal drainage. Fourteen months later the convulsions recurred on the right side. A right hemiplegia developed. The pneumoencephalogram showed collections of air over the left motor cortex and a distortion of the ventricles. The convulsions continued in spite of all treatment until the child died at 3½ years. Necropsy showed areas of destruction in the cortex, as indicated in the roentgen films, the result of intracranial hemorrhage at birth. Obviously, treatment could not be of avail.

Case 2.—N. B., 2½ years of age, had had fainting spells since he was 9 months of age. He had had twelve a day, in spite of adequate doses of phenobarbital and "dilantin-sodium." Neurologic examination was negative, mentality was normal, and left hemiplegia was present. Pneumoencephalogram was normal; operation revealed no abnormality.

Case 3.—S. A., 8 months of age, one day at the age of 3 months had several convulsions. Then she was well until 8 months old when she again developed convulsions. Examination revealed infant in coma. Pneumoencephalogram shows air only over the right cortex. There was no response to phenobarbital or "dilantin-sodium."

Case 4.—D. C., 2 years of age, was the first born infant, delivered after an eighteen-hour labor. She had a convulsion at 2 weeks of age, and was slow in mental and physical development. At 2 years of age she went into status convulsus which lasted six days. Subsequently she had generalized athetosis and incoordination. Convulsions were controlled with phenobarbital. Pneumoencephalogram shows distortion of ventricles and internal hydrocephalus.

Case 5.—L. T., 5 years of age, had had convulsions for 2½ years. He was a breech presentation delivered by forceps. He bled from the nose and mouth after delivery and vomited a great deal. Physical examination was negative except for an evident mental retardation. The pneumoencephalogram shows an internal hydrocephalus with marked dilatation of the ventricular system. The child has had no convulsions since the air injection.

Conclusions

A pneumoencephalogram will always provide valuable information even if it appears to be normal. In many cases it will provide a great surprise in revealing lesions entirely unexpected and unrecognizable by any other means. Every child with a chronic convulsive disorder is entitled to a pneumoencephalogram before a final diagnosis is made and before a decision is made concerning treatment. A normal pneumoencephalogram does not positively rule out an organic lesion, but it provides great assistance in instituting medical treatment. Pneumoencephalography is a major operation and must be so represented to parents.

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Pneumonia in Children Treated With Sulfapyridine*

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SULFAPYRIDINE is proving itself an effective chemotherapeutic agent in the treatment of pneumococcic pneumonia. Although lobar pneumonia in infants and children has never been the serious disease that it is in adults, the children are usually severely ill. It is a revelation to see these small patients with a normal temperature and clinical improvement within twelve to twenty-four hours after the start of chemotherapy, in contrast to the several days of severe illness before a crisis occurred, as was our previous experience.

Sulfapyridine has not only proved effective in pneumococcic infections, but it has also had a beneficial effect in streptococcic, staphylococcic, and H. influenzae bacillus infections experimentally produced in animals. While it seems to be more effective in pneumococcic pneumonia, there is no reason to withhold its use in any pneumonia until the correct bacteriological diagnosis can be made. A clinical trial of the drug during this period will establish whether or not it is to be of value.

At the Children's Memorial Hospital sulfapyridine has been used almost routinely in all cases of lobar pneumonia for the last eighteen months. The results which we obtained for the first fifteen months are here summarized. There were 244 cases of pneumonia admitted to the hospital. This does not include those cases in which there was a questionable diagnosis, nor those cases in which the temperature became normal within a few hours after admission to the hospital. It is not always easy to differentiate between a lobar and a bronchopneumonia, but from clinical and roentgenological examinations a diagnosis of lobar pneumonia was made in 197 children and of bronchopneumonia in forty-seven.

* Presented at the 99th anniversary meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1940.

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Dosage

Since children tolerate sulfapyridine very well, a slightly larger dose was usually used than for adults. The drug was always given orally. A dosage of approximately 1 gr. of sulfapyridine per pound of body weight per twenty-four hours was usually given. In very ill or toxic children this was sometimes increased to 1½ to 2 gr. per pound for the first twenty-four hours. In infants under 1 year the dose varied between 1 and 1½ gr. per pound. The twenty-four hour dosage was divided equally into four or six doses, depending upon whether a four or six hour schedule was to be used, there being little if any preference between the two. The initial dose was always made double the amount of the regular dose. This full dosage was usually continued for forty-eight hours after the temperature became normal and was then decreased by one-fourth for twenty-four to forty-eight hours and then one half the original dose for another one to two days, depending upon the appearance of the child and the disappearance of the physical findings. Five gr. of sodium bicarbonate were given with each dose of sulfapyridine. As an example, a 6 year old boy weighing 40 pounds was given an initial dose of 1 Gm. of sulfapyridine followed by ½ Gm. (7½ gr.) every four hours for two days, and then every six hours. The drug was given for five days, the total amount being about 200 gr. A 3 year old child, weighing 33 pounds, was given an initial dose of 1 Gm. and ½ Gm. (7½ gr.) every six hours for a total of 120 gr. in four days. An 8 month old infant, weighing 19 pounds, was given an initial dose of ½ Gm. (7½ gr.) and 3.8 gr. every four hours for two days and then every six hours for a total of about 80 gr. in five days. We have had no experience with the sodium salt of sulfapyridine, but it has been reported as giving satisfactory results when administered rectally.

If the medication was vomited, the same dose was immediately repeated. The drug can be given crushed with sugar in a small amount of orange juice or water or it can be given with cereal or fruit. It seems to be better tolerated when given with food. In a series of 125 uncomplicated cases of lobar pneumonia sulfapyridine was given for an average of 4.8 days. This varied from two days to an extreme of ten days. There was an average of 5.9 doses given before the temperature became normal.

When sulfapyridine was being administered, the usual foods given to pneumonia patients were offered. There is no contraindication for the use of other drugs such as aspirin, codeine, phenobarbital, etc., which are commonly used in the treatment of pneumonia. Some of the children were so severely ill that oxygen was given for varying periods of time. A few children also received antipneumococcus serum intravenously.

Blood stream concentrations of sulfapyridine varied between 1.7 and 9.0 with an average of 4.02 mg. per cent per cubic centimeter of blood. Concentrations between 4.6 and 5.22 mg. per cent per cubic centimeter of empyema fluid were found in the few cases in which such examinations were made.

Lobar Pneumonia

Of the 197 infants and children who had lobar pneumonia 161 received sulfapyridine and thirty-six were treated without the drug. In four of the treated children the sulfapyridine was stopped; because of vomiting and inability to retain the medication in three, and within twenty-four hours because of a leucopenia in one patient. One child with a lobar pneumonia and a pure culture of hemolytic streptococci from the throat developed an otitis media and a mastoiditis so it was impossible to tell when the pneumonia subsided and the mastoiditis began. Neither sulfapyridine nor sulfanilamide appeared to be effective in this child.

To simplify the evaluation of sulfapyridine the treated cases of lobar pneumonia will be divided into various groups; 133 cases responding by uneventful recovery; twenty-three having or developing an empyema (one death); and the five cases discussed above.

The 133 patients with lobar pneumonia treated with sulfapyridine included infants

and children up to 11 years of age with a fairly even distribution throughout all age groups. It was estimated the pneumonia started on an average of 3.1 days before hospitalization. The temperatures became normal after the initial dose of sulfapyridine on an average of 1.1 days. In four patients the temperature remained elevated four days; in one 3.5 days and in one, three days. In all the others it returned to normal in twelve to twenty-four hours. An average of six doses of the drug was given before a normal temperature occurred but this varied with individual cases, depending upon whether a four or six-hour medication schedule was used. The drug was administered for an average of 4.8 days, this varying from two days to as many as seven to eight days in a few patients. The average hospital stay was 9.2 days.

In seven children the sulfapyridine was administered for only twenty-four hours, the total daily amount being given either in one dose or in two divided doses twelve hours apart. The results of therapy in these seven patients paralleled that of the group above except that the temperature remained elevated about ten hours longer. In several other children in which this twenty-four hour treatment was tried the temperature did not remain normal and the usual method of therapy had to be adopted.

Comparing these results with those in twenty-eight similar cases of lobar pneumonia which did not receive sulfapyridine it was found that in the latter group the pneumonia had been present an average of 4.6 days (1.5 days longer than in the treated group) before hospitalization. In spite of this the temperature remained elevated 5.2 days after hospitalization as compared to 1.1 days in the treated patients. The untreated patients remained in the hospital an average of 12.8 days which was 3.6 days longer than the treated patients.

Pharyngeal swab cultures were negative for pneumococci in twenty patients. Type 1 pneumococcus was cultured in fifteen patients, type XIV in ten, type III in three, type XVIII in two, and types II, IV, VI, XIII, XIX and group IV were cultured in one patient each.

Bronchopneumonia

There were forty-seven cases of bronchopneumonia during the period of this study, and of these twenty-eight received sulfapyridine. In twenty-four uncomplicated cases, the temperature returned to normal in an average of 2.2 days after the start of chemotherapy. In eleven patients with bronchopneumonia not given the drug, the temperature remained elevated an average of 4.1 days.

Empyema

Chemotherapy.—Of the 161 cases of lobar pneumonia treated with sulfapyridine twenty-three or 14 per cent developed an empyema. In all but six of these patients roentgenograms showed evidence of fluid within twenty-four hours after sulfapyridine was started.

In twelve of these twenty-four patients only a small amount of fluid was present and the empyema disappeared spontaneously. In one patient the temperature became normal twelve hours after the start of the drug; in six after five to seven days, and in five after eleven to nineteen days. In one patient the sulfapyridine was given for two days and then stopped because of a leucopenia but in the other cases it was given for an average of 11.3 days (a range of eight to twenty days). No pharyngeal swabs were made on five patients. Of those on whom pharyngeal swabs were made three were negative for pneumococci; one was a group IV pneumococcus, and one each types I, VIII, and XV. In the latter culture hemolytic streptococci predominated.

In five patients with empyema, recovery took place after aspiration alone. Three patients were aspirated one time, one three times, and one four times. In one patient the pleural fluid was clear and negative upon culture (the only time this occurred) although a group IV pneumococcus was cultured from the pharynx. In another patient type I pneumococcus was cultured from both the pleural fluid and the throat. Hemolytic streptococci were cultured from the pleural fluid of three patients, one having a negative throat culture, one a hemoly-

tic streptococcus, and the other a type VI pneumococcus on pharyngeal culture. The latter patient received 195,000 units of type VI antipneumococcus serum intravenously. Both of the streptococcic empyemas received sulfapyridine for seven to nine days before being given sulfanilamide. The temperatures returned to normal in thirteen to eighteen days after the start of chemotherapy. Such therapy was continued for four days in the patient with clear fluid, for eight days in the patient with the type I pneumococcus infection and for thirteen, seventeen and twenty-seven days in the last three patients.

A rib resection after one to four aspirations was necessary in five patients. Cultures of both the pharynx and the empyema fluid revealed a type I pneumococcic infection in three patients and a group IV and a type XIV in one each. These patients remained in the hospital from two to three and one-half months and their courses varied little from that of empyema treated without chemotherapy.

One 8 month old infant entered the hospital critically ill with a severe hemolytic streptococcic throat and mouth infection. Sulfanilamide was not tolerated. Several days later a lobar pneumonia developed, accompanied by a pyopneumothorax and a general sepsis with multiple abscess formation (hemolytic streptococci). Death occurred after five days of sulfapyridine therapy.

No chemotherapy.—Of the thirty-six patients with lobar pneumonia who did not receive chemotherapy six, or 17 per cent, developed an empyema. In three patients the fluid disappeared spontaneously. In these the temperatures returned to normal in four, six and eleven days. In the other three patients a rib resection was necessary after three to four aspirations. Two were type I and one was a type XIV pneumococcic infection. Hospitalization was carried out for two months in two patients and for three and one-half months in the other.

In this series of cases chemotherapy did not alter the frequency nor the course of empyema, nor did it produce sterile pleural fluids.

Bronchopneumonia.—Only one case of bronchopneumonia treated with sulfapyridine developed an empyema. Recovery took place after one aspiration of 300 cc. of a cloudy fluid which was sterile upon culture (type I pneumococcus cultured from the pharynx). The temperature remained elevated for twenty-one days and the patient was discharged from the hospital in five weeks.

Effect of Sulfapyridine Therapy Upon Lobar Pneumonia

	Treated with Sulfapyridine	*Treated without Sulfapyridine*
Number of Cases	161	36
Average number of days ill before hospitalization	3.1	4.6
Average number of days before temperature became normal	1.1	5.2
Average number of days in hospital	9.2	12.8
Average number of days of therapy (2 days to 10 days)	4.8	
Average number of doses of sulfapyridine before temperature became normal	6.0	
Occurrence of empyema	23 or 14%	6 or 17%
A. Spontaneous recovery	12	3
Average number of days before temperature became normal	1 to 19	4 to 11
Days sulfapyridine given	8 to 20	
B. Recovered with aspiration only	5	0
Average number of days before temperature became normal	13 to 18	
Days sulfapyridine given	4 to 27	
C. Recovered after rib resection	6	3
Average days in hospital	60 to 100	60 to 100

Mortality

Lobar pneumonia.—Only one child with lobar pneumonia that received sulfapyridine died. This was the patient, eight months of age, with a hemolytic streptococcal general sepsis with abscess formation, discussed under the empyema cases. Two patients with lobar pneumonia who did not receive chemotherapy died. Death occurred fifteen days after admission in one 3 year old child from whom type I pneumococcus was cultured from both the pharynx and the blood stream. Treatment consisted of oxygen and 180,000 units of type I antipneumococcus serum intravenously. The other patient, aged two months, died six hours after admission with a staphylococcus aureus septicemia, lung abscess and fibrous pleurisy.

Bronchopneumonia.—Death occurred in three patients with bronchopneumonia who received sulfapyridine. Two patients, ages four months and one month, survived for thirty-six hours after admission. Postmortem examination revealed besides the bronchopneumonia an intraventricular septal defect with transposition of the great vessels in the former, and in the latter, a cardiac hypertrophy with what was interpreted as a fetal endocarditis. The third patient, aged nine months, received 100,000 units of type VII antipneumococcus serum intravenously, as well as sulfapyridine, surviving for one month although critically ill during all of this period. Upon postmortem examination an unresolved bronchopneumonia, a necrotizing bronchitis, a bilateral hemolytic streptococcal pleurisy and a hemolytic streptococcal septicemia were found.

Death occurred in eight of the nineteen patients with bronchopneumonia who did not receive chemotherapy. Seven of the patients, from one to eighteen months of age, were moribund upon admission, four dying within six hours and three within twenty-four hours after admission to the hospital. The other child, four months of age, survived for eleven days. These patients did not receive chemotherapy because they were admitted before sulfapyridine was being used or died before effective doses could be given.

Toxic Reactions

Minor toxic manifestations are much more frequent than the serious ones. It is important to remember that toxic manifestations do occur and that all patients receiving sulfapyridine should be closely observed, especially after the third day of drug administration in order that these toxic reactions may be recognized and the proper steps taken to counteract them.

Nausea and vomiting are by far the most frequent toxic manifestations of the drug. If the drug is vomited it will often be retained if given again immediately. In three children the drug had to be discontinued before a therapeutic effect could be obtained, because of vomiting. In three others it had to be stopped temporarily or was stopped as soon as the temperature became normal.

Cyanosis to a mild degree was occasionally present but never caused concern sufficient to discontinue the drug.

Hematuria developed in seven patients after two to six days of medication. In two of these it did not occur until twenty-four hours after the drug had been stopped. The sulfapyridine was always discontinued when hematuria occurred. Decreased urinary output and other abnormal urinary elements were never present.

Fever and dermatitis were not encountered.

Anemia, leucopenia and neutropenia developed in a few cases, but acute hemolytic anemia was not encountered. It is sometimes difficult to know whether an anemia or even a leucopenia is due to the infection or is a reaction to the drug. The same holds true for neutropenia, especially in infants. When leucopenia and neutropenia are present or become evident, one should be exceedingly careful if the drug is to be continued. Severe anemia developed in four children after from ten to twenty-three days of sulfapyridine therapy. There was a 35 to 50 per cent decrease in the hemoglobin and in the red blood cells. Transfusions were given as much for the infection as for the anemia, with rapid improvement.

A leucopenia of 2,600 white cells without neutropenia developed in one patient after seventeen days of therapy. The drug was

discontinued for four days with an increase of the leucocytes above normal after which therapy was again started without recurrence of the leucopenia. A mild leucopenia occurred in thirteen other children, the white cell count being in the six thousands in three, in the five thousands in six and in the four thousands in four. In only six of these patients was the drug stopped. The drug had been administered for two to twenty-four days.

A neutropenia occurred in nine patients, three of whom also developed a leucopenia. The polymorphonuclear cells decreased from an average of 70 to 80 per cent to an average of 20 to 30 per cent with a corresponding increase in the lymphocytes. Spontaneous rapid recovery occurred without therapy in all cases.

In two patients not receiving sulfapyridine mild leucopenias occurred. There was also a decrease in polymorphonuclear cells to as low as 28 per cent. This illustrates how the reaction of the patient to the infection may be the cause of the leucopenia and neutropenia rather than the sulfapyridine.

Conclusions

1. In our series of cases of lobar pneumonia treated with sulfapyridine the temperature returned to normal and there was clinical improvement in an average of 1.1 days as compared to an average of 5.2 days in a group not receiving chemotherapy.

2. Hospitalization averaged 3.6 days longer in the cases not receiving sulfapyridine.

3. Sulfapyridine did not seem to influence the frequency or the course of such complications as empyema.

4. Sulfapyridine also appeared to be a moderately successful therapeutic agent in the treatment of bronchopneumonia.

5. As the mortality was low in both the treated and untreated cases in this series, no conclusions can be drawn as to the effectiveness of therapy in this respect.

6. Minor toxic manifestations of sulfapyridine therapy were fairly common. Patients receiving chemotherapy should be closely observed.

7. Sulfapyridine is a real contribution to the therapy of lobar pneumonia.

Irradiation Treatment of Carcinoma of the Cervix*

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THE literature relating to carcinoma of the cervix uteri is so voluminous that one hesitates to add to it, but since the condition is so common and so uniformly fatal when treated improperly, I shall ask your indulgence while we consider the question anew.

Statisticians disagree regarding the relative frequency of carcinoma of the cervix, some placing it first in the entire group of malignant tumors while others, admitting that it ranks first in women, still insist that gastric neoplasm is more common in the population as a whole.

The etiology of cervical carcinoma is still not definitely known, but it appears that trauma of childbearing, with subsequent infection has a definite bearing. All evidence points to this relationship and that of endocervicitis and cervical erosions as markedly increasing the incidence of the disease. This theory has further substantiation in the fact that the cervix is a common site for the appearance of squamous metaplasia due probably to the constant injury and repair process which is going on in this region.

The disease is most common in the fifth decade but may be found very early in life or very late. Even though the symptomatology is or should be well known to every therapeutic radiologist, it is well to recall

* Presented before the Section on Radiology of the State Medical Society of Wisconsin, La Crosse, May 17, 1940.
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that the onset may be exceedingly insidious and that when gross and arresting symptoms appear the disease may be in the late stages. Bleeding, however slight, that occurs between normal menstrual periods should always be investigated. Coitus or douching may cause such bleeding. But while bleeding may be a frequent symptom, it may be entirely absent until late in the disease. A vaginal discharge, more frequently watery and prone to be foul, may also be the first symptom. Again the primary symptom may be a gross and violent hemorrhage which may be almost exsanguinating. Any change in quality, quantity, character or periodicity of the menstrual periods should be immediately investigated, and this always means a bimanual and speculum examination. Too many physicians are prone to temporize and give symptomatic treatment when the condition should be carefully investigated. This is especially true when the patient is in or near the menopause.

Pathology

About 5 per cent of cervical neoplasms are adenocarcinomata while the remainder are epidermoid. Cervical carcinoma may originate on the portio, on either lip or in the cervical canal. It may arise in a frank ulcer and begin by a downgrowth of the new epithelium into the deeper structures or it may originate as a more diffuse atypical overgrowth of epithelium over a wide area of the portio or canal. The cervix is superficially eroded and inflamed in these instances.

As the process extends, the lesion may grow superficially and form an exophytic or everting type of tumor or it may invade, destroy deeper tissue, ulcerate and become endophytic or inverting. A superficial lesion may develop into either type, as may a lesion arising in the cervical canal. Bulky tumors may fill the upper vagina while ulcerating lesions may destroy the entire cervix and penetrate into the bladder or rectum.

Spread of the carcinoma is (1) locally by direct extension into the parametrium or anteriorly or posteriorly into the bladder or rectum, (2) by the lymphatics to the pelvic nodes, or (3) to distant points probably through the blood stream. Pearson[3] found that 25 per cent of his 57 cases studied at autopsy had distant metastases, the liver being most frequently involved.

As you know, clinical grouping of carcinoma of the cervix is made either according to Schmitz or League of Nations into four categories. Schmitz Group I includes the earliest lesions, Group II the lesions still confined to the cervix, Group III those with extension into the parametrium and Group IV if the pelvis is frozen, if there is involvement of the bladder or rectum or if there are distant metastases. The League classification of Stage I includes Schmitz I and II while Schmitz III is divided as II and III of the League.

Because of the squamous metaplasia that not infrequently occurs over the cervix, conditions arise in which it is impossible to tell whether the lesion is an actual carcinoma or one of the so-called precancerous lesions. This is not only true clinically but may even be so microscopically. This raises the question of biopsy for proof of the actual condition. This should be done in all cases in which any suspicion has been aroused of the existence of a neoplasm. Usually, of course, the diagnosis is definite clinically, but a biopsy should be taken in all cases not only for scientific reasons but because occasionally a lesion simulating carcinoma may not be one. We have had at least one case in which, although the lesion was clinically typical, biopsy showed tuberculosis.

Since there are a great many cases with so-called cervical metaplasia or precancerous lesions, it has been necessary for us to attempt to crystallize our opinion as to what is the proper treatment of such cases. Many of these patients go for years without showing definite signs of carcinoma. Therefore we take the position that they should be treated conservatively by cervical amputation or radium alone. If the pathological and clinical opinion shows undoubted, even though early, carcinoma we are strongly of the opinion that a full course of internal and external irradiation should be given, somewhat along lines which follow.

Treatment

Internal.—The treatment of carcinoma of the cervix is essentially an irradiation problem. I do not mean that carefully selected cases in proper hands cannot with benefit be operated on, but I do stress the fact that the usual general surgeon should not operate on this condition. Too many patients lose their only chance of recovery because they are treated surgically. In the hands of the experienced pelvic surgeon as many as 40 per cent of the operable cases may be saved, but since only about 50 per cent of the cases are operable, the absolute cure rate is only about half of the above or about 20 per cent. Primary mortality is in the neighborhood of 15 per cent.

In the treatment of carcinoma of the cervix, therefore, the accepted method is irradiation. This can be divided into two main components; (1) that applied for its effect on the local lesions, and (2) that given for control of cells beyond the immediate neighborhood of the cervix. For irradiation of the primary lesion, radium has a deservedly high reputation, but it has at least two weaknesses: First, its insertion is associated with trauma in almost all cases. This not only increases the chances of stirring up infection and forcing restricted dosage due to the accompanying febrile reaction, but the manipulation enhances the chances for dissemination of neoplasm due to the opening up of fresh channels, both blood and lymphatic. Second, the rapid falling off of depth dose percentage with radium means that only cells within close proximity to the radium get a lethal dosage even when the outlined total dosage is given. This again means that local necrotizing doses must be given or else the slightly outlying cells must be undertreated. Some of the disadvantages of this local treatment can be obviated by making proper use of the distensibility of the upper vagina and placing the radium foci at greater distance from the mucous membrane. To do this means careful measurement of the distensibility of the upper vagina, and accurate placing of radium in line with these measurements. According to Tod,[10] 18 per cent of vaginas can be dilated up to 7.5 cm., 24 per cent from 5 to 6.5 cm. and 58 per cent less than 5 cm., and advantage of this should always be taken to increase the depth dose.

In order to supplement the radium treatment because of its inherent limitation, roentgen irradiation has been used and today the vast majority of workers in this field prefer a combination of roentgen rays and radium. Wintz[12] is the outstanding, and almost only, exponent of the use of transpelvic roentgen rays alone. For a while, radium alone was used by some clinics either in the early cases or in all groups, but further work, notably that by Heyman[3] and Lacassagne,[5] indicates that clinical results are better if roentgen rays are always used, even in the earliest cases, because of possible non-detectable involvement distant from the obvious lesion.

In our work, we have used a combination of roentgen rays and radium, increasing gradually the external irradiation in order to approach more closely the lethal dose for tumor in the areas at a distance from the primary lesion. From a radium dosage of about 3,000 mg. hr. ten years ago, we have increased it until now we routinely give from 5,500 to 6,000 mg. hr. as a total of vaginal and cervical canal radium treatment. This is given with two tubes in the cervical canal and a plaque of 10 mg. capsules against the cervix.

I would like to emphasize at this point, however, that total number of milligram hours is by no means an accurate indication of effective dosage because, as Tod[10] has pointed out, the anatomic factors are so variable that total dosage, as expressed by amount of radium element times hours, may be very misleading. Such information must be modified to include the number of foci and the amount in each focus, the filter, the location and the distance of each focus from the nearest mucous membrane or other normal tissue. Only in this way can one judge the amount of radium treatment really given. The most satisfactory method is one which permits the calculation, in roentgens, of the dose at any given point by methods such as those of Walker,[11] Holthusen,[4] and Tod.[10]

When both radium and roentgen rays are used, the sequence of application is im-

portant. Since the majority of these patients come in with fairly advanced malignant disease, infection, either superficial or deep, is a common complication. Any manipulation of this infected neoplasm tends to spread infection and open up channels for tumor dissemination. Therefore, we prefer to give our roentgen ray treatment first in all except the very early cases in which a biopsy is necessary to establish a diagnosis. This is usually followed by reduction in the size of the neoplasm and at least partial clearing up of infection. In this way, subsequent use of radium is not only made safer but is usually easier because of a tendency to restoration of anatomic relationships.

One must not wait too long before using radium, however, because (1) the additional treatment is needed, and (2) the formation of adhesions in the apex of the vagina may render the application of radium more difficult. Repeated biopsies have shown us that it is unsafe to rely on external irradiation alone to sterilize the local lesion. We like to apply our radium within three weeks of the termination of external irradiation and frequently immediately following it.

Although attempts at direct roentgen irradiation of the primary lesion were made years ago, they were not successful, due mainly to the fact that tube design and electrical protection had not reached the point of making this method safe. With the advent of shockproof tubes and cables, however, these drawbacks were removed and the method has again begun to be used. Schaeffer and Witte[9] in Germany have designed a tube to be run at 100 K. V. whereby the target is inserted into the vagina and the radiation delivered direct to the lesion. While this is a definite advance, I think the relatively short distance and low kilovoltage do not offer a high enough depth dose percentage. In my opinion, the work that is being done by Merritt[7] and Erskine[1] with 200 K. V. and greater distances with a consequent increase in depth dose percentage is a definite advance in the treatment of these lesions. This method changes a deep-seated lesion into a relatively superficial one and all of us know the relative ease with which superficial lesions can be made to regress. Merritt and Erskine do not agree as to the details of application of roentgen radiation direct to the cervix either in regard to the division of dosage or method of exposure. Merritt uses a hard rubber Ferguson speculum with an obturator for ease of insertion and a lead ring for protection of the vulva. He uses 220 K. V., 2.0 mm. Cu. filter and about 38 cm. target lesion distance, and gives 1,000 roentgens each day for five successive days. Erskine uses an expanding blade speculum which gives him a greater field than the limitations of the vaginal introitus and consequently allows more irradiation to get farther out into the parametrium. This is, of course, to be desired. When using the hard rubber speculum, there is also some spread of the beam but since the rays traverse the wall of the speculum in an oblique direction, the filtering thickness is about 10 mm. instead of the actual wall thickness. With 133 K. V. and 2 mm. Al. filtration this leaves only 29 per cent coming through the speculum wall while with 200 K. V. Thoraeus filter it is approximately 45 per cent. Direct treatment of the cervical lesion gives a much more homogeneous irradiation than can be obtained with radium. Erskine measures a depth dose percentage of 50 at a distance of 4 cm. below the tip of the speculum with an opening of 31 mm., and this is obviously more than can be expected from any ordinary radium application. He gives about 1,170 roentgens once a week for three weeks. Following the course of external irradiation, this transvaginal course is repeated. At intervals of one month, two more single transvaginal treatments are given.

Our transvaginal irradiation is now being given with 133 K. V. while we are waiting for adaptation of one of our 200 K. V. machines for this type of work. With this we use the Ferguson speculum with 2.0 mm. Al. filter and 26 cm. distance. We began by giving 500 roentgens three times a week for a total of 5,000 roentgens but soon changed to 1,000 roentgens twice a week because of the increasing difficulty of insertion of the speculum due to reaction. Even this distribution of dosage may make the last application quite painful. Reaction on the mucosa

of the cervix and upper vagina is quite similar to that seen in the mouth after intensive treatment. We always attempt to use the largest speculum, which measures 3.8 cm. inside diameter but because of the introitus we are sometimes forced to use a smaller size. Reaction following 3,000 to 4,000 roentgens occasionally necessitates our using a smaller speculum. So far we have treated only 18 patients by this method but the immediate results have been exceedingly encouraging.* Reactions about the vulva and perineal body are sometimes quite distressing but have always healed up quite satisfactorily.

Treatment

External.—It is obvious that the salvage of any except the earliest cases must depend on some method of treatment besides roentgen or radium irradiation to the primary lesion because neither will give a lethal dose for tumor far enough beyond the cervix. This treatment must therefore be mainly transpelvic roentgen irradiation. Our object must therefore be to give a lethal dose for tumor throughout the parametrial area. From the work of Martin, Quimby and Pack,[6] Walker[11] and our own experience we feel safe in assuming that we must endeavor to deliver ten threshold erythema doses to all parts of the lesion. This will mean that in the neighborhood of 5,000 roentgens will have to be given to the parametrium, and this is not a simple matter.

Our present method of external irradiation consists of using 200 K. V., 50 cm. distance, and the Thoraeus filter which gives us a half value layer of 1.9 mm. of Cu. We give the treatment through two anterior, two lateral, and two posterior 10 x 15 cm. ports and to these six we add two 10 x 10 cm. gluteal ports. Our anterior, lateral, and posterior ports are placed so that the lower border comes at the level of the lower margin of the pubis and the anterior and posterior ports are directed straight down with the medial edge of the cone placed at the midline of the patient. An occasional 8 x 10 perineal port is added where transvaginal irradiation is not given. Two ports are treated each day in rotation until a total of from 15,000 to 20,000 roentgens as measured in air has been given.

It is important to remember that total roentgens either in air or on the skin are of relatively little value and assume importance only when correlated with other treatment factors such as number, size, and location of ports, distance, filter, quality of beam, intensity, and daily dose; and even with these factors an adequate concept of the treatment can not be obtained without knowing the tumor dose. This in turn must be based largely on the size of the patient. We, therefore, caliper our patients carefully with the cones in position and, since we use the Holfelder type of pressure cone, we can measure the patient with the cone applied. Direct measurements with the ionization chamber at the cervix convinces us that it is safe to use depth dose tables in correlation with careful calipering of the patient both externally and from the perineum to the cervix to calculate the amount of irradiation delivered from any port to the cervical area. We find that we can increase our parametrial dose 25 to 30 per cent by use of the gluteal port.

Weight is used as an important indication of the rapidity with which our treatment is given and, generally speaking, patients who weigh more than 150 pounds will tolerate 300 roentgens as measured in air given to each of two ports daily when there are at least eight ports. If the patients weigh less than 150 pounds, we find that 200 roentgens to each of two ports per day is enough. We also use weight as an indication of the tolerance of the patient to treatment and any patient who loses an undue amount of weight will probably not be able to tolerate the full course of treatment. Heavy patients, of course, are allowed to lose relatively more weight than light ones who are watched very carefully in this respect.

Reactions

General reactions such as nausea, vomiting, malaise, and anorexia are combatted by the use of Vitamin B_1 or the whole Vitamin

* At the time of publication, we had treated more than 75 cases with direct roentgen irradiation to the cervical lesion.

B complex and by the use of the grounded wire gauze mask as recommended by Friedman and Drinker.[2] Irradiation reactions we take only as an indication of the patient's tolerance. Erythema, tanning, vesiculation, and desquamation we take to be routine concomitants of all treatment which is taken to its logical conclusion. For these we use only bland ointments unless there is superficial infection. We then use gentian violet either in aqueous solution or as an ointment. We find that psychic preparation of the patient is of considerable value and each one is told of reactions to be expected and is prepared for them. The patient's confidence increases as predictions come true. Only occasionally must we discontinue treatment before we feel it advisable or, in other words, because the patient insists on stopping.

Bladder irritation in these cases is uncommon in our experience although we see it occasionally. Rectal irritation is not uncommon and may be the cause of our discontinuing treatment. Diarrhea is controlled by the use of lead and opium pills or small retention oil enemata.

We should never lose sight of the fact that the patient is of prime importance and that it is really the patient we are treating. There have been times when in our enthusiasm for delivering more irradiation to a given lesion we have forgotten this basic principle and have consequently lost both neoplasm and patient. Although I am sure that compromise is too frequently resorted to, I am equally certain that in all cases the patient must be the primary consideration. This is especially true in regard to the aged, the very sick, and those who are thin either from disease or naturally.

We take the position that the best results in the treatment of these malignant tumors are obtained when complete treatment is given at the first course. Repeated courses of treatment have proved disastrous in our hands. Permanent skin changes have resulted in some cases with doses up to 3,000 roentgens per port but these changes are infrequent. Permanent changes in bowel and rectum have been encountered but practically all of these have occurred in thin patients where there is a large depth dose percentage or where changes could be accounted for on the basis of the radium treatment. We have seen no direct relationship between size of the port and daily dose and the damage to the bowel and rectum, but all of our long and heavy courses have been given with ports no larger than 10 x 15 cm. Our experience leads us to believe that it is difficult but not impossible to produce permanent damage to normal internal tissue in large patients with the multiple port arrangement. In smaller patients, however, this complication is a definite possibility if caution is not exercised.

Fracture of the neck of the femur has occurred in one case of carcinoma of the ovary where a total air dose of 16,800 roentgens was given over a period of about ten months and once in a patient treated for carcinoma of the cervix when 5,700 roentgens (air) were given to the side of the fracture. Most of our patients have received larger doses than these and I have no explanation for the occurrence of fractures in these cases. Possibility of such a complication does not deter us from giving the usual heavy dose.

Prognosis and Results

The prognosis in carcinoma of the cervix is becoming gradually better, not so much because patients are being seen earlier but because the technique of treating them is becoming better. This is due to the fact that many therapists have not been and cannot be satisfied with a static type of treatment but must always be seeking for some improvement that the rest of us can follow.

An examination of our own results is encouraging. From July 1, 1926 to July 1, 1930, there were 92 patients with carcinoma of the cervix treated entirely at the University Hospital and of this group 23.9 per cent lived five years without evidence of disease. In the next four-year period, we had 155 patients treated by us alone with a 19.7 per cent survival. These figures exclude patients who had been treated elsewhere first and were then referred to us. In the calendar year 1934, we treated 53 patients exclusive of those partially treated elsewhere and of

this group we had a five-year survival of 41.5 per cent. It is interesting to note that Group I cases (5) had 100 per cent survival, Group II (11) had 72.7 per cent, Group III (32) had 28.1 per cent while none of the 18 Group IV cases survived five years.

While these figures are encouraging, it does not indicate to me that we have reached the maximum results because I am not yet convinced that we have exhausted the possibilities with either roentgen or radium irradiation and certainly not with 200 K. V.

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The Adequacy of Iodized Salt For Goiter Prevention*

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FOLLOWING the demonstration[1] that colloid goiter could be prevented or cured by use of small doses of iodine given during childhood and adolescence, there arose a suspicion that universal use of iodine by the population in the "goiter belt" might be dangerous. This was because of fear that an induced thyrotoxicosis would follow[2] in a significant number of adults. This fear has been dispelled in most quarters[3, 4] by the experience of the past quarter century. During this time iodine has been used on personal prescription, administered in tablet form to school children in large groups, and has been made available to the entire population of certain urban areas by iodization of water supplies. The most popular form of iodine supply has become the iodized table salt which is now provided by most manufacturers of salt as an alternate form of boxed or bag salt. Two further criticisms of this form of iodine supply have been expressed: the iodine content of such salt may be variable and unstable,[5] and dependence upon such a source of iodine may not provide adequate amounts for small children who add no salt voluntarily to their food. The work reported herewith is to contribute to the answer which can be given to this latter question.

A study of urinary iodine excretion will provide information about the amount of iodine available to the individuals examined. It has been shown[6] that urinary iodine parallels iodine intake, and in healthy individuals is the largest factor in iodine excretion. In goitrous regions iodine excretion is lower than in non-goitrous areas. It has been shown[7, 8] that during pregnancy the use of iodized salt provided adequate amounts of iodine. The iodine excretion of a group of children in a goiter area such as Wisconsin, selected from homes where all table and cooking salt in use was iodized salt, should provide data for decision as to the adequacy of iodized salt as the chief source of iodine

* The cost of technical work and transportation of specimens was defrayed by a grant from the Committee on Goiter of the State Medical Society of Wisconsin.

in childhood. Therefore, such observations were made on 10 children, varying in age from 1.7 to 12 years. These children were chosen from the homes of a number of physicians in different parts of the state who were able to assure us that urine collections were complete and not contaminated, that only iodized salt was in use, and that the child was not aware of being observed as to salt intake and its correlated iodine supply.

The twenty-four hour urine samples were collected in clean glassware supplied for the purpose. Analysis was carried out by one observer only, following the method of Matthews, Curtis and Brode.[9] The results are presented in tabular form. A wide variation in amounts of iodine is to be expected. That they scatter from 53 to 594 micrograms per twenty-four hours as compared with data reported from other laboratories is not surprising. The marked differences between determinations of different twenty-four hour samples from the same child are similarly expressive of the well known variation in the intake and output of sodium chloride.

Age in years	Iodine excretion in micrograms per 24 hours
1.7	53
	74
2.8	550
	488
4	108
5	165
5.5	58*
	238
6–8	78
7–9	281
	411
10	594
12	138
	69
12	271

Extremes: 53 to 594.
Average: 238.

* On this day the mother knows no salt was used in preparation or serving this child's food.

There is no distinct age trend to higher iodine excretion. The minimum value recorded is 53 micrograms, which is of the same order of magnitude as the findings of Curtis and his associates[6] in Ohio subjects for which they used similar analytic methods. Among males in the first decade, in a goitrous region, they found an *average* of 41 micrograms per day. The average iodine excretion in non-goitrous regions is reported by the same investigators as 165 micrograms. It is suggested by Curtis[10] and others[11] that an excretion of 50 micrograms per day represents approximately the lower level of normal iodine need. Therefore the results reported here appear to indicate that the use of iodized salt by children leads to iodine intake fully adequate for prevention of goiter. Even though this series of cases is small, with the number of specimens per subject only one or two each, and the variations wide, the general levels of iodine excretion seem well above any dangerously low margin. It is concluded that the use of iodized salt by families will provide adequate iodine intake for the needs of most children. If the physician considers additional iodine is necessary temporarily, due to rapid growth or increased demands on the thyroid during acute infection, there is no difficulty in prescribing such iodine to meet the need.

Of course there are further problems requiring attention in the manufacture and sale of iodized salt. The amounts of iodide to be added, the use of further additions to the salt for other purposes in control of quality of shaker salt, and the uniformity of iodine content during the interval between manufacture and eventual consumption require attention. Some students of these questions[11] advise use of salt with only 1 part of iodine per 100,000 of salt. Daily intake of 50 micrograms of iodine would depend on use of an average of 5 Gm. of such salt daily. Many adults do not use this amount, and certainly not all children will have an adequate iodine intake under such conditions. Some of the most commonly used brands of iodized table salt in the United States at present contain 1 part of iodine per 5,000 of salt. With this concentration, the use of only 1 Gm. of salt per day provides an intake of 200 micrograms, which is well above the margin of need for goiter prevention. It would be necessary to limit salt intake very drastically to keep the daily total as low as 1 Gm. daily. Consequently, it seems probable that salt with only 1 part of iodine per 10,000 parts of sodium chloride will be able to provide an abundance of iodine for prevention of goiter. It is suggested that since

prevention of goiter is a health measure of importance to the entire population in many states of this country, and since iodized salt is not only convenient, safe, and economical but also effective and dependable, the control of iodine content of salt should become a function of state health authorities.

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Evaluation of Medical Treatment in Rheumatoid Arthritis

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RHEUMATOID arthritis is an acute or a chronic symmetric progressive polyarthritis characterized by periarticular swelling, atrophy of the muscles in the affected joints, limitation of motion due to fibrous destruction of the joint spaces, and atrophy of the bone.

There is no one etiologic theory which has yet proved satisfactory. Hench[1] says the cause of atrophic arthritis is still unknown and that the evidence for infection, although impressive, is incomplete.

The treatment of rheumatoid arthritis in general has been hard to evaluate. This is especially true of new therapeutic measures where no statistical study showing the difference between the results in treated and untreated cases has been published. The tendency of the disease to become chronic, its irregular tendency to spontaneous remissions, and the ineffectiveness of therapy in many of the cases, further complicates the problem of treatment.

"Specifics" are usually of no avail and the occasional good results are followed by many bad ones. It is generally agreed that every patient should be treated as an individual problem and by a composite program, not by one favored remedy.

The present study is based on material collected from physicians and clinics particularly interested in rheumatic diseases and to a very limited experience of the writer.

Management of Focal Infection

Haden[2] says that focal infection is concerned only as an influencing factor in rheumatic arthritis and a point at which a specific organism is harbored. If the infection does get in through the throat, it seems to do so as well after removal of the tonsils as before. The conservative removal of the obvious foci of infection was urged to improve the patient's general health. It is important that focal infection be removed early in the course of the disease rather than later. It is seen that at rare intervals the removal of teeth and tonsils produces very good results but patients should be told that such results are not common.

Vaccines

The use of autogenous vaccines given intravenously or subcutaneously in smaller doses by Breuer[3] gave impressive results. Of 212 patients with atrophic arthritis reported by Crowe,[4] 5 per cent became symptom free, 35 per cent were much improved, 41 per cent were improved, and 19 per cent were unimproved. Of Voss'[5] 86 patients, 16 were cured or very much improved, 36 were improved, and 34 were unimproved.

The writer has used Crowe's vaccines for some eleven years. The results have not been comparable to those of Crowe or his colleagues. Of 23 cases of rheumatoid arthritis 3 became symptom free, 8 were improved, and 12 were unimproved.

Crowe's vaccine used consisted of both streptococci and staphylococci. It has been shown by Crowe that staphylococci are just as frequently involved in rheumatic disease as are the streptococci.

The good results have occurred in the early and the subacute cases. Unimpressive results have occurred in the chronic cases. It is important that small descending doses be used, although the results are slower and favorable results take months and not weeks of treatment. The consensus of opinion of many physicians is that vaccines should not be used alone but in conjunction with other therapeutic measures.

In some cases results were better when febrile reactions were induced. This was done by giving 25, 50, and 100 million bacteria of the stock typhoid vaccine in 10 cc. of normal saline solution at weekly intervals for three doses. It has been noted that the use of normal saline solution alone gives beneficial results.

Haden[2] has used non-specific vaccines with good results. For this, he used the stock typhoid-paratyphoid vaccine. For the first treatment, 25 million bacteria in 10 cc. normal saline solution are injected intravenously. Each succeeding injection is given after twenty-four hours of normal temperature. The second dose is 50 million bacteria in 10 cc. of normal saline solution, and the third dose 100 million bacteria. The temperature reaction following the first injection usually lasts longer than forty-eight hours, so the second injection should not be given before seventy-two hours. The succeeding injections are of shorter duration and so the third dose is given forty-eight hours after the preceding dose. This course of vaccines can be given during the course of injections of autogenous vaccines with beneficial effects. Typhoid vaccines are best given as an aid when the patient is improving. Edgecombe[6] says that one fault of vaccine therapy is that many patients are treated by vaccines only for long periods, and gradually pass into a hopeless condition when other measures might have been beneficial.

Colloidal Sulphur

The report of the Council on Pharmacy and Chemistry of the American Medical Association[7] has revealed that none of the leading arthritis clinics which have given sulphur therapy a trial is continuing its use. The report accused the proponents of this therapy for arthritis of being careless in the detail of their cases, negligent about the proper typing of the cases of "arthritis" under treatment, and not sufficiently sure of the indications.

Gold Salts

Gold salts have been widely used in England and to a lesser extent in this country. Although the treatment is empiric, the drug is considered by most observers as a distinct advance in treatment. A serious criticism to its widespread use has been its toxicity. The toxic reactions are common and provide the greatest objection to this form of therapy. The most important of the toxic effects are headache, giddiness, vomiting, fever, albuminuria, abdominal upsets, joint reactions, stomatitis, exfoliative dermatitis, toxic jaundice and the blood dyscrasias (purpura, agranulocytosis, aplastic anemia and the drop in blood platelets). Stomatitis and dermatitis are common and are most frequent when larger doses are given. There are no specific methods known for the prevention of toxic reactions or for the determination of hypersensitivity of individuals to the drug. Reactions may occur from large or small doses. It is therefore evident that careful consideration should be given this

drug before it is used. Goldie[8] says the blood sedimentation rate is of little value in anticipating either relapse or severe toxic reactions. The most severe upsets occurred in the presence of a normal rate.

The commonly used gold salts are gold sodium thiomalate (myochrisine), (Van Breeman), parmanil (Hartfell, Garland and Goldie), solganol B (Van Breeman, Stone), allochrysine (Stone), and sanocrysin (Secher).

The general plan of treatment, according to Stone,[9] was to give injections of gold every five to seven days; the initial dose was 10 mg., subsequent doses of 20, 50 and 100 mg., the maximal single dose being 100 mg., the total amount for one course being 1 Gm. which is reached in a space of ten to eighteen weeks. The drug is given either by vein or intramuscularly. Douthwaite[10] gave, in acute cases, 10 mg. for each of three doses, then if no reactions occurred, 50 mg. for each of six doses, then 100 mg. doses thereafter until 1.5 Gm. of solganol or myochrisine was given or 2 Gm. of allochrysine; in less acute cases six or seven doses of 50 mg. each, thereafter 100 mg. each dose. Ellman and Lawrence[11] gave to one group of patients 10, 50, 100 and thereafter 200 mg. each dose up to a total of 2.5 Gm. Another group received smaller doses of 10, 20, 40, 75, and thereafter 100 mg. each dose until the sedimentation rate fell below 10 mm. (one hour). These doses were estimated for nine to twelve months. Ellman and Lawrence[12] say no harm results from prolonging the first course no matter how large the total dose, provided the sedimentation rate remains high and the leukocyte and platelet count remains satisfactory. The plan of limiting the first course to 1 Gm. is likely to produce numerous failures. Six weeks after the end of the first course, they began the second course, this time until 50 mg. had been given as a maximal dose.

The results of treatment provide definite evidence that gold preparations favorably alter the course of the disease in cases of rheumatoid arthritis. In Hartfall, Garland and Goldie's[13] series of 50 patients in which they used parmanil, cures resulted in 4 per cent. In 26 per cent of the cases reactions occurred, varying from slight toxic in 14 per cent, moderate in 6 per cent and severe in 6 per cent. Seventy-four per cent showed no reaction.

The treatment of reactions is purely symptomatic. The skin and urine should be examined weekly and blood examinations made at frequent intervals. A change in the blood from a leukocytosis to a leukopenia may point to an impending dermatitis.

Bee Venom

Bee venom is supposed to act as a foreign protein, as a counterirritant, as a desensitizing agent, or through a histamine-producing action. Burt,[14] in his report of 200 cases, 50 of which were analyzed, gave the following results: 32 per cent of the patients were much better, 18 per cent were better, 30 per cent were unchanged, and 20 per cent were worse. Bee venom treatment is not specific but of value in certain selected cases, and is worthy of further consideration.

Chaulmoogra Oil

A preparation containing 90 per cent chaulmoogra oil, 10 per cent olive oil and 0.2 per cent benzocaine was used by Smith, Blocker and Tumen[15] in 15 cases of atrophic arthritis, and in 87 per cent the symptoms disappeared. The oil was injected intragluteally eight times in six weeks. It was found to be irritating, painful and in one instance a sterile abscess developed.

Diets

There is no particular diet for arthritis. Myers[16] says a diet should provide an optimal nutrition, relief of constipation, and an abundance of vitamins and minerals, and should avoid foods to which patients may be sensitive.

Vitamins

It is generally believed that this type of therapy is worthy of research investigation but not as a remedy suitable for general practice. Haden[2] says that many patients with rheumatoid arthritis show evidence of nutritional deficiency disease. The lack is

not the cause of the disease but may be an influencing factor—hence, the indication for diets adequate in vitamins.

Summary and Conclusions

The present day specific therapeutic measures for this type of arthritis are based mainly on the reports of those interested in this disease. The following conclusions are hereby merited.

1. Crowe and many of his colleagues are enthusiastic advocates of his vaccines. The impressive results obtained by Crowe and others are generally questioned by many workers. Tegner[17] having observed the use of vaccines in American and European clinics concluded, "In the present state of our knowledge of the etiology of rheumatoid arthritis, the use of vaccines cannot be either endorsed or rejected." The use of small descending doses gives the best results. The early cases are best suitable for treatment. Vaccine therapy will receive more enthusiastic response when given correctly and when used in conjunction with other proved forms of therapy. The present fault is that many patients are treated only with vaccines until the patient is beyond the help of other proved measures.

2. Sulphur therapy has been discontinued by most of the leading arthritis clinics as of no apparent effect.

3. Gold salts have proved a distinct advance in the treatment of this disease. The toxic reactions following injections have proved a serious criticism to its use. It is apparent that most toxic reactions have occurred with normal sedimentation rates or when the rate has been below 12 mm. Careful dosage guided by frequent sedimentation rates may eliminate the serious objections to gold therapy.

4. Bee venom is not specific but of value in certain selected cases.

5. Chaulmoogra oil has been found to be irritating, painful and of questionable value.

6. Vitamin deficiency, according to Haden, is not the cause of the disease, but may be an influencing factor. The giving of vitamins is therefore important.

7. A cardinal principle in the treatment of this disease is that the patient must be treated as a whole. A carefully planned medical program guided by a complete history, and physical and laboratory examinations must still prevail as the best regimen to follow.

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Comments on Treatment

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Frostbite and Allied Conditions

In peacetime only the physician in northern rural climates is apt to see more than an occasional case of frostbite. In wartime with men stationed in cold climates, the subject assumes great importance, and it behooves the physician to become familiar with its prevention and treatment. We can learn much from the experience of the English, and this article is based on a recent paper of Greene which appeared in Lancet (December 6, 1941).

There are various types of frostbite. The most familiar is the sudden frostbite of which the "nipped ear" is the most common example. The gradual frostbite in which the painful sensation of extreme cold gives way to a pleasant numbness is more serious since the damage to tissues is much more extensive. On thawing a flush surrounds the frozen area and invades it. Swelling due to transudation follows, and if the damage is severe, blood may escape into the injured tissue causing it to appear dark blue.

"Trench-foot" can be considered a form of gradual frostbite, although it is usually produced by a temperature that is above freezing. It is now recognized that dampness, constriction and stagnation of circulation, fatigue, and malnutrition are important contributory factors. Likewise the new entity, "shelter-foot," (a swelling of the feet of one who spent the night in a sitting position without compensatory rest in a horizontal position during the day) has as its main causative factor venous stagnation and possibly increased capillary permeability. A third form, namely "immersion-foot" is seen in men who have been forced to spend a long time in waterlogged boats.

Much can be done to prevent frostbites. The need for adequate clothes is obvious, and the importance of dry socks especially must be emphasized. In the last war it was found that rapid marches just before the men entered the trenches were particularly prone to cause "trench-foot." Sleeping in the sitting position and standing motionless for a long time leads to venous stagnation and thus predisposes to frostbite. The need for exercising the muscles of the leg while standing is to be emphasized. Much foot trouble can be avoided by gently massaging the feet with whale or other types of animal oil. The wearing of rubbers or rubber boots when it is necessary to stand or work in cold mud has been found very effective in reducing "trench-foot." The nutritional state is also an important factor and an adequate supply of citrus fruit is undoubtedly beneficial since it prevents capillary hyperpermeability.

In the treatment of frostbite two things must be avoided: excessive warmth and undue friction or rubbing. The frostbitten part must be kept cool and gentle warmth be applied very slowly. Rubbing beyond the stage of very mild massage can only cause destructive damage and increase the danger of infection.

The seriousness of frostbite must be constantly kept in mind. If the feet are involved, the patient should be transported by stretcher, and if the hand or arm is frozen, the affected part must be carried in a sling. It is advisable to paint the part with a non-irritating antiseptic solution and to cover it with sterile dressings. Complete rest of the traumatized part is essential. It is advisable to give antitetanic serum. Supportive treatment, hot foods and drinks, and warmth to the unaffected parts of the body are helpful.

Hasty amputations should be avoided except in cases of spreading and uncontrolled sepsis. It is surprising how often a foot or a hand can be saved that appeared discouragingly bad and hopeless. A. J. Q.

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Annual Subscription--------Three Dollars-Fifty Cents Single Copies--------Fifty Cents

Advertising Representative: Cooperative Medical Advertising Bureau, 535 North Dearborn St., Chicago, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, Madison

Volume 41 JANUARY, 1942 **Number 1**

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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« « « EDITORIAL » » »

Innovations in the Journal

WITH this issue of *The Journal,* two added features are presented. One of them is an adaptation of a section carried by *The Journal* twenty-five years ago, then entitled "Medical Mobilization and the War." The considerations that prompted Dr. Rock Sleyster, then editor, to provide the members of the State Medical Society with valuable material gathered under this one head are doubtless the same that prompt the present section entitled "The Nation at War." This section will feature current items of value in the whole war endeavor. Members are urged to note the material as it appears on page 53, and subsequent issues.

Dean Chris L. Christensen, dean of the College of Agriculture and director of the Agricultural Experiment Station of the University of Wisconsin, inaugurates the first of a series of articles dealing with the importance of Wisconsin products in nutrition. In his article entitled "Butter in National Health," page 50, Dean Christensen makes a valuable contribution to the columns of *The Journal.* At the conclusion of the series, all articles including that on "Butter in National Health," will be available in reprint form. The contribution of Dean Christensen to current literature on butter is a noteworthy addition to our *Journal.*

Introducing Dean Christensen

IT IS my privilege as president of the State Medical Society of Wisconsin to present to our members the first contributor to this educational section on nutrition, our first line of home defense. Mr. Chris L. Christensen, dean of the University of Wisconsin College of Agriculture and director of the Agricultural Experiment Station and Agricultural Extension Service since March, 1931, is well known both to Wisconsin citizens and to the Nation. He was secretary of the Federal Farm Board from 1929 to 1931, and for five years previous to that he was head of the Division of Cooperative Marketing, Bureau of Agricultural Economics, U. S. Department of Agriculture.

After serving in World War I and receiving his Bachelor of Science degree from the University of Nebraska, he was research fellow of the American-Scandinavian Foundation to Denmark to study agricultural economics and cooperative agriculture in 1921–1922. Mr. Christensen did graduate work in economics and marketing at the University of Copenhagen and the Royal Agricultural College, Denmark, 1921–1922, as well as in economics and business administration at Harvard University, 1923–1924. In 1937 the University of Nebraska conferred on him an honorary degree, Doctor of Agriculture.

While studying and doing research in the Scandinavian countries, Mr. Christensen gave special attention to the economic development of Danish agriculture and cooperative organization, later preparing a publication on "Agricultural Cooperation in Denmark," which has had unusually wide distribution among farmers in the United States and Canada, and also has been translated and distributed in several foreign countries. Mr. Christensen is also author of numerous other articles on agricultural problems.

In 1922 and 1923 Mr. Christensen was employed in the capacity of research agent in the U. S. Department of Agriculture to investigate agricultural marketing and cooperative organization among farmers in Denmark, Sweden, Norway, Finland, Germany, Czechoslovakia, Switzerland and England. As a member of the staff of the Bureau of Agricultural Economics of the U. S. Department of Agriculture from 1924 to 1926, Mr. Christensen was engaged in directing and conducting research in farm cooperative organizations, marketing and distribution of agricultural products.

When Congress passed the Federal Cooperative Marketing Act in 1926, creating the Division of Cooperative Marketing in the U. S. Department of Agriculture, he was put in charge of the division. Mr. Christensen was one of the leaders in the organization of the American Institute of Cooperation in 1924 and took an active part in the 1925 and 1926 summer sessions which were held at the Universities of Pennsylvania and Minnesota under the auspices of the American Institute of Cooperation.

When the Federal Farm Board was organized in 1929, Mr. Christensen was selected as its first executive secretary, serving in this executive capacity for nearly two years. During this initial period Mr. Christensen was entrusted with large administrative duties and executive responsibilities in the organization of the Federal Farm Board's various departments, selection of personnel and operating policies and procedures.

We are fortunate to have Dean Christensen prepare this article for *The Wisconsin Medical Journal.* His work with problems of the farmer, and his intimate knowledge of the farmer's value to his community and to his country, qualify him as an outstanding expert and authority in his chosen field. We welcome Dean Christensen to the columns of *The Wisconsin Medical Journal* with a truly deep appreciation of his kindness.

—GUNNAR GUNDERSEN, M. D., La Crosse.

CHRIS L. CHRISTENSEN

Butter in National Health

By CHRIS L. CHRISTENSEN

Dean, College of Agriculture, and Director, Agricultural Experiment Station, University of Wisconsin

BUTTER is a tasty, highly concentrated food product, with great nutritional values. It furnishes large quantities of heat energy, ranking far ahead of sugar in caloric value, and it is an excellent source of certain vitamins and accessory food substances which promote the growth, health, and well-being of man. As butter is easily and almost completely digested, these nutritional substances are made available for utilization by the human body.

Those are some of the chief reasons that butter is regarded by scientists as a valuable addition to any menu, and those are the reasons given by Conrad Elvehjem, nationally known biochemist at the University of Wisconsin and member of the Food and Nutrition Committee of the National Research Council, for regarding butter as a good food product for all ages.

Wisconsin Has High Standard

Although butter is uniformly good as a food, different samples vary in composition and quality, according to Elvehjem. Butter produced under different conditions may contain anywhere from 70 to 90 per cent fats. State laws, however, protect the consumer by requiring that butter for public sale must contain at least 80 per cent fats. The natural color of butter may vary from deepest yellow to almost white.

Vitamin A and Carotene

While vitamin content may also vary in different butter samples, vitamin A, the fat-soluble food substance necessary for the prevention of certain types of skin disorders and eye conditions such as night blindness and xerophthalmia, is found in all butter. Its occurrence in nature is associated with the yellow plant pigments, the carotenes, which are converted in the human or animal, yielding vitamin A.

The measurements of the vitamin A content of butter are complicated by the vitamin A-carotene relationship.

Butter with a high carotene content, and consequently bright yellow in color, may have a low vitamin A content, and still have a high potency, since carotene is converted to vitamin A in the body. Vitamin A itself is a colorless, oily substance, and butter with a high vitamin A content, and virtually colorless, has a low carotene content. Therefore, while a good natural dark yellow tone is a good indication of the presence of carotene, absence of that color does not mean that the butter is deficient in total vitamin A.

June Sets Pattern For Winter Feeding

A change in dairy ration will alter the vitamin content of the butter produced. By taking dairy animals off pasture a source of carotene is removed from their diet, and the vitamin A value of the butter produced from their milk drops off as much as 50 per cent. However, dairymen, now recognizing this fact, are taking measures to prevent this decrease by supplementing the winter feeding with rich, green alfalfa hay or other products high in carotene.

Butter as a Source of Vitamin D

Vitamin D is also present in butter, and while it may vary in amount in different samples of butter, all butter is a fair source of this vitamin which is so essential to the bony structure. The natural source of vitamin D, of course, is sunlight, and thus it has been found that butter produced during the winter months from the milk of animals deprived of sunlight and pasture is lower in vitamin D content than is butter produced during the summer months when the animals are on pasture and in the sunlight.

Physicians recognize, of course, that fish liver oils are far superior to butter in supplying the antirachitic factor so important in preventing rickets and osteomalacia. However, butter furnishes an auxiliary supply of vitamin D, and artificial enrichment of it by ultraviolet rays makes it an even better source.

New Butter Factor

Most recent research has revealed a new factor in butter, as yet unnamed. The substance has never been isolated, and although work is now going ahead rapidly on it, all that is yet known is that young animals grow much better when supplied with it than when fed only vitamins A and D and supplementary fats of a non-dairy origin.

Digestibility of Butter

The digestibility of butter is uniformly good. All fats with a low melting point are easy to digest, and butter is in this class of fats, ranking second only to fish liver oils in ease of digestion and completeness of utilization. Besides, butter on digestion yields fatty acids of low molecular weight, which play an important role in the process of metabolism.

Human Requirements

About two ounces of good butter daily will supply the vitamin A requirements of an average child, and two to three ounces of butter with a pint of whole milk daily will be quite adequate for an adult's vitamin A requirements. Butter is not to be depended upon alone for an adequate supply of vitamin D, although its value as an accessory source of vitamin D is very important. Just what amount of the newly discovered "butterfat growth factor" is required for normal growth, and to what degree butter is adequate in supplying it, have not been established. However, research indicates that butter may prove adequate to supply man's requirements of this substance.

The importance of the nutritional value of butter was not always as fully recognized as it is today. Scientists had known for years that fats are needed for human growth, but until the early part of this century, when E. V. McCollum made his first studies at the University of Wisconsin, little else was known, and no attempt had been made to determine which fats are needed and why.

Orientals Found Way to Prevent Beriberi

It was through a sequence of experiments performed over a period of more than a quarter century that there was ultimately brought to light the present, though yet incomplete, knowledge of this unnamed factor present in butter, which we do know to be essential to growth. Included in this series of investigations was the search for the cause of beriberi.

When beriberi and other nervous disorders were taking their yearly toll of human lives in Japan in the 1870's it was suspected that this disease was the result of some undiscovered micro-organism. That suspicion was substantiated by the fact that the disease appeared among the low-class fishermen, farmers, coolies, and river-dwellers, who lived in crowded areas in Japanese villages. The disease took its biggest toll immediately after heavy floods, and this again confirmed the bacterial theory, since almost all diseases caused by bacteria make their heaviest ravages in flood time when drinking water and food are apt to be polluted.

When the disease broke out, during the Russo-Japanese war, and despite isolation, spread rapidly among the sailors in the Mikado's navy, a more concentrated effort was made to determine the nature and cause of the disease. Reference to earlier medical records revealed that a Dutch scientist named Eijkman, working in the Dutch East Indies, had made experiments on pigeons, producing a disease not unlike beriberi. Eijkman had produced this disease spontaneously in birds isolated from any chance of contagion, and his final conclusions were that the disease was a result of feeding the pigeons polished rice. This lent impetus to the search being made by the Japanese admirals, since the staple food on their navy's ration was polished rice. With a change in their ration to unpolished rice the disease subsided, and thereafter the sailors were served unpolished rice.

While this brought to light an important feature of the disease, it still had not revealed the fundamental cause of beriberi. Scientists began a search for the element, apparently present in the outer shell of unpolished rice, which prevented beriberi, and the first suspect was phosphorus. Fraser and Stanton discarded that view, however, when they found that an extract from rice polishings containing only 15 per cent of the total

phosphorus would still prevent beriberi, while the remaining 85 per cent phosphorus extract had no control over the disease.

Meanwhile Funk, in Poland, had isolated a compound from rice polishings, which within a few hours restored the ability to fly to a pigeon, paralyzed by neuritis. However, he had neither identified nor analyzed his new "vitamin."

Wisconsin Investigations Fundamental

At this time E. V. McCollum, a young Yale graduate, was just entering the field of nutritional investigation at the University of Wisconsin, working under the direction of Professors E. B. Hart and the venerable Stephen Moulton Babcock. While taking his "apprenticeship" at the Wisconsin Experiment Station, young McCollum read with interest these reports of the search for the food factors so vital to life and good health.

One item in particular interested him; the story of the German scientists who had fed rats a diet completely balanced but containing phosphorus only in the inorganic state. The German scientists had reported that their animals died for the lack of this phosphorus, but McCollum questioned their findings. He tried the test himself, and discovered that the rats he fed lived and grew to be fat and healthy. One animal nearly doubled its weight in less than two months on this same diet, which the German biochemists had claimed was fatal to their rats.

Osborne and Mendel, American scientists, trying a similar experiment and following the procedure of their tests, had the same results as the German scientists. This was perplexing to McCollum, as well as to other scientists, and he proceeded to determine wherein his experiments differed from those of the other workers. He compared the rations used, and found that in his own ration he had used butter for the source of fat in the diet, while the other two experimenters had used lard. From this McCollum learned that butterfat is essential to growth and health, and tests conducted later by himself and a co-worker, Margaret Davis, verified this conclusion. Osborne and Mendel worked independently, and shortly after McCollum and Davis published a report in June, 1913, they told of a butterfat and egg yolk factor which greatly promoted growth, revealing that certain eye conditions and skin disorders could be traced to a deficiency of that butterfat factor.

One Vitamin or Two?

At first scientists wondered whether McCollum's discovery involved the same element which Funk had found in rice polishings. However, experiments were performed, and rats from the same litter placed side by side, one living on a diet which included only rice polishings, and the other on a diet including butterfat alone, made minimum growth gains. Only the animals which received both compounds were strong and healthy. These results indicated that there were two factors involved. In 1916, McCollum further clarified the matter by naming the element which Funk had discovered vitamin B, and the butterfat factor, vitamin A.

Vitamin B, then believed to be a simple compound, but now revealed to be a complex collection of separate vitamins, appeared in green vegetables, eggs, nuts, and liver. That is the reason beriberi had followed floods, which had destroyed vegetable gardens and poultry houses, leaving only polished rice and fish for the people to eat.

Tests performed to determine the source of vitamin A had revealed its presence in quantity in the fish liver oils and in butter. Later investigations to determine the source of vitamin D revealed that butter was also fairly rich in the sunshine vitamin.

Butter Contains a "Growth Factor"

After these experiments the scientists were satisfied that they knew all there was to learn about butter, until Edwin Bret Hart, University of Wisconsin biochemist, began some additional experiments. Some of his experiments, together with other work carried on in the biochemistry department, convinced him that there was something yet unrevealed in butter; that there was an accessory growth substance which did not occur elsewhere. This factor is as yet unnamed.

(Continued on page 82)

The Nation at War

In this section of *The Journal,* to appear monthly for the "duration," there will appear pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Complete Plans For Handling Professional Personnel in War

Function of Procurement and Assignment Service and Names of Committeemen for Corps Areas Are Announced

AN OUTLINE of the organization of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians and the names of the corps area committeemen representing the three professions are announced in the Medical Preparedness Section of *The Journal of the American Medical Association* for December 27. The announcement says:

"At a meeting in Chicago of the board of the Procurement and Assignment Service with the Committees on Medical Preparedness of the American Medical Association, the American Dental Association and the American Veterinary Medical Association, a definite organization was completed for the functioning of this service in relationship to needs of professional personnel in the war.

Physical Requirements for Physicians in Service

"The Procurement and Assignment Service will make available shortly through publication in the periodicals of the professions concerned a tabulation of the physical requirements for physicians applying to any of the federal services.

Evaluation of Physicians Through County Medical Societies

"More than two thousand county medical societies have already made available ratings of physicians available in such counties as regards their employment in essential services and their availability for the Army and Navy Medical services. Steps will be taken to speed up the completion of similar evaluations in the remaining counties.

Questionnaire

"Approval was given to the immediate publication in the professional periodicals of a questionnaire addressed to all members of the medical profession urging them to enroll at once with the Procurement and Assignment Service so as to make available immediately a pool of physicians from whom applicants for commissions might be drawn promptly. The immediate needs of the Army are for men in the grades of lieutenant and captain—that is to say, men particularly under the age of 45.

The National Roster

"A conference was held with representatives of the National Roster, which is a subsidiary of the National Resources Planning Board. Arrangements were made for joint action with the Budget Committee in Washington to secure the necessary funds for operation of the National Roster covering the medical profession and for the regional office in the headquarters of the American Medical Association.

Corps Areas

"Dr. James A. Paullin (Atlanta, Ga.) described the methods by which evaluation has been made of all men in the Fourth Corps Area and also the method by which ratings have been given to specialists.

"Approval was given to the constitution of committees in each of the corps areas and associated naval districts to function as advisory to the corps area commander, the

committee to consist of a chairman who will be the corps area representative of the Committee on Medical Preparedness of the American Medical Association, one physician representing medical education, one representing the hospital organizations, two physicians selected at large, two dentists and one representative of the veterinary profession. The chairmen nominated for the various corps areas are as follows:

First—Dr. W. G. Phippen, Salem, Mass.
Second—Dr. A. W. Booth, Elmira, N. Y.
Third—Dr. A. M. Shipley, Baltimore.
Fourth—Dr. Edgar Greene, Atlanta, Ga.
Fifth—Dr. E. L. Henderson, Louisville, Ky.
Sixth—Dr. Charles H. Phifer, Chicago.
Seventh—Dr. Roy W. Fouts, Omaha.
Eighth—Dr. Sam E. Thompson, Kerrville, Texas.
Ninth—Dr. Charles A. Dukes, Oakland, Calif.

"Other physicians nominated to these corps area boards include:

First—Dr. Deering G. Smith, Nashua, N. H.; Dr. Lucius Kingman, Providence, R. I.
Second—Dr. S. J. Kopetzky, New York; Dr. W. J. Carrington, Atlantic City, N. J.
Third—Dr. C. H. Henninger, Pittsburgh; Dr. Hugh H. Trout, Roanoke, Va.
Fourth—Dr. Alfred A. Walker, Birmingham, Ala.; Dr. Edward H. Jelks, Jacksonville, Fla.
Fifth—Dr. Robert Conard, Wilmington, Ohio; Dr. Larue Carter, Indianapolis.
Sixth—Dr. J. Milton Robb, Detroit; Dr. Stephen E. Gavin, Fond du Lac, Wis.
Seventh—Dr. F. L. Loveland, Topeka, Kan.; Dr. Robert L. Parker, Des Moines, Iowa.
Eighth—Dr. Holman Taylor, Fort Worth, Texas; Dr. John W. Amesse, Denver.
Ninth—Dr. John Fitzgibbon, Portland, Ore.; Dr. John H. O'Shea, Spokane, Wash.

"A regional office is to be established in each corps area for the maintenance of information, for supervision of the state committees and to act as a consulting body on all matters relating to the functions of the Procurement and Assignment Service in the corps area. The following dentists were recommended for appointment:

First—Dr. Philip Adams, Boston; Dr. Frank W. Rounds, Boston.
Second—Dr. William McG. Burns, Brooklyn; Dr. Allan T. Newman, New York.
Third—Dr. Lucian Brun, Baltimore; Dr. Harry Bear, Richmond, Va.
Fourth—Dr. Claude R. Wood, Knoxville, Tenn.; Dr. Ralph R. Byrnes, Atlanta, Ga.
Fifth—Dr. Earl Lowery, Columbus, Ohio; Dr. Wendell Postle, Columbus, Ohio.
Sixth—Dr. Leo Kremer, Chicago; Dr. Paul H. Jeserich, Ann Arbor, Mich.
Seventh—Dr. F. A. Pierson, Omaha; Dr. A. W. Bryan, Iowa City.
Eighth—Dr. H. G. Duckworth, San Antonio, Texas; Dr. Fred C. Elliott, Houston, Texas.
Ninth—Dr. B. C. Kingsbury, San Francisco; Dr. E. G. Sloman, San Francisco.

"The following veterinarians were recommended for appointment:

First—Dr. R. W. Smith, Concord, N. H.
Second—Dr. R. R. Birch, Ithaca, N. Y.
Third—Dr. Mark Welsh, College Park, Md.
Fourth—Dr. B. T. Simms, Auburn, Ala.
Fifth—Dr. A. F. Schalk, Columbus, Ohio.
Sixth—Dr. Ward Giltner, East Lansing, Mich.
Seventh—Dr. H. D. Bergman, Ames, Iowa.
Eighth—Dr. M. B. Starnes, Dallas, Texas.
Ninth—Dr. C. M. Haring, Berkeley, Calif.

"The names of the physicians representing medical education and those of the hospital organizations will be published later.

"The technic was also described for supplying the names of physicians to appropriate governmental agencies according to the present methods of functioning of the Procurement and Assignment Service."

15,000 NURSES NEEDED TO TEACH RED CROSS HOME NURSING

Today every citizen is a part of national defense. Daily, many more young men are added to our Army and Navy. Nurses are enrolling as Red Cross first reserves to serve with the Army and Navy. Private citizens are being trained as volunteer nurses' aides in hospitals and clinics. And now comes a demand from homemakers and schools for classes in Red Cross Home Nursing to prepare them to protect the health of their families.

Red Cross Home Nursing courses have been taught since 1914. During 1941, 80,939 persons successfully completed courses taught by some 2,500 nurse instructors. With about 500,000 persons requesting this instruction now, six times as many instructors will be needed in 1942.

The standard course requires 24 hours of classroom work, generally given in two hour sessions twice a week, in which the Red Cross textbook is used. A Guide for Instructors, and special materials for classroom use, are provided the teacher. With a demand for morning, afternoon, or evening classes, the time can be arranged to suit the instructor.

Insignia For Volunteer Civilian Defense Workers

THE Office of Civilian Defense has prepared insignia for volunteer civilian defense workers to wear after they have been enrolled and trained. There is one basic insigne bearing the initials "CD" in red, enclosed in a white triangle superimposed on a blue field, which is to be worn on cap and uniform collar ornaments of all civilian defense workers. Each of the fifteen activities has a distinctive design to be worn on white armbands or embroidered on the left sleeve of uniforms 1 inch below the shoulder seams. The designs have been patented by the OCD, and only enrolled civilian defense workers are entitled to wear them as part of uniforms or to any clothing that would simulate official wear. Workers or their defense councils will pay for the insignia with the possible exception of the armbands. Congress has been asked to authorize funds to distribute the latter.

Physicians and nurses serving in emergency medical field units will be identified by a red caduceus in a white triangle set in a blue circle. In the event of a war emergency such as an air raid, the problem of caring for the sick and injured will be handled by the Emergency Medical Service. Field units composed of doctors, nurses and nursing auxiliaries will set up casualty stations near the site of disaster for the purpose of giving assistance to the injured and expediting their transport to a hospital when necessary. Teams of doctors, nurses and assistants will be dispatched from this station to establish advanced first aid posts closer to the scene of the emergency.

Volunteer nurses' aides will be identified by a red cross within a white triangle set in a blue circle. This indicates that the volunteer has been enrolled and trained by the American Red Cross for service in civilian defense.

Special training by the Red Cross and by hospitals designated as training centers is required of nurses' aides. When they have completed the prescribed instruction they will become eligible to assist nurses in wards and outpatient clinics of hospitals, or in visiting nurse, public health, industrial hygiene and school health services. The insigne must not be worn until the course of training has been completed.

MEDICAL CORPS

The Emergency Medical Field Units will be identified by a red Caduceus in white triangle set in blue circle.

In the event of a civilian disaster or in a war emergency such as an air raid, the problem of caring for the sick and injured will be handled by the Emergency Medical Service, the character and size of which will be established by the local Chief of Emergency Medical Services. Emergency Medical Field units composed of doctors, nurses, and nursing auxiliaries will set up a Casualty Station near the site and give assistance to the injured. Teams of doctors, nurses, and assistants will be dispatched from this station to establish advanced First Aid Posts close to the scene of emergency.

The wearing of this insigne is limited to workers enrolled in the Emergency Medical Service in the Wisconsin civilian defense organizations.

NURSES AIDES CORPS

Volunteer Nurses' Aides will be identified by a red cross within white triangle set in blue circle. This indicates that the volunteer has been enrolled and trained by the Red Cross for service in Civilian Defense.

Special training by the Red Cross and by hospitals designated as Training Centers is necessary before women volunteers can serve as Nurses' Aides. Upon the completion of instruction they will become eligible to assist nurses in wards and out-patient clinics of hospitals or in visiting nurse, public health, industrial hygiene, and school health services. The insigne must not be worn until the course has been satisfactorily completed.

The wearing of this insigne is limited to workers who are enrolled in the Volunteer Nurses' Aides Corps in the Wisconsin civilian defense organizations.

A Call to the Medical Profession

THE nation is at war. The Congress has passed an amendment to the Selective Service Act which will call for registration of every man up to the age of 65 and which will place all men under 45 years of age subject to service at the order of the Selective Service boards.

The Procurement and Assignment Service for Physicians, Dentists and Veterinarians was established by order of the President on October 30. Thus the medical profession itself aids in determining proper distribution of the medical profession in supplying the needs of the armed forces and maintaining medical service to civilian communities, public health agencies, industrial plants and other important needs.

At a meeting of the Procurement and Assignment Service held in Chicago at the headquarters of the American Medical Association on December 18, jointly with the Committees on Medical Preparedness of the American Medical Association, the American Dental Association and the American Veterinary Medical Association, plans were drawn for making immediately available to the United States Army and Navy Medical Corps the names of physicians who wish to be enrolled promptly in the service of the government in this emergency.

On the opposite page is published a blank by which every physician may at once place his name with the Procurement and Assignment Service as one who is ready to serve the nation as the need arises. If you wish to make yourself available for classification, fill out this blank and send it at once to Dr. Sam F. Seeley, executive director of the Procurement and Assignment Service. When these blanks are received, they will be classified and checked with the information available in the national roster of physicians at the headquarters of the American Medical Association.

For 2,009 counties in the United States, lists have been prepared indicating physicians who are engaged in necessary civilian projects, public health services or educational activities from which they cannot be spared. Shortly the rest of the counties will have such lists available.

In each of the corps areas covering the United States a committee is being established, including representatives of medical, hospital, educational, dental and veterinary activities. In the individual states, committees of medical, dental and veterinarian professions are being established through which the corps area committees will exercise their functions. In each county also local committees will provide accurate information regarding the status of each member of the profession concerned.

The raising of the Selective Service age from 28 to 45 will place a great number of additional physicians in the category of those on whom the nation may call as their services are needed. Estimates indicate that some 60,000 physicians thus become available for service and that 42,000 dentists under the age of 45 also become subject to call. By enrolling with the Procurement and Assignment Service immediately, utilizing the blank on the opposite page, all physicians, but particularly those under 45 years of age, insure to every extent possible assignment to the type of service for which they are best fitted. They avoid thus also the possibility of unclassified service with the United States Army during the period that may be necessary following selection by the Selective Service before the commission can be secured. A physician called by the Selective Service who has not enrolled or who is not on a reserve list obviously serves without a commission during the time that necessarily elapses before a commission is secured. In future issues of *The Journal of the American Medical Association* and *The Wisconsin Medical Journal* announcements will be made regularly of the numbers of those who enroll and of the extent to which the immediate needs of the Army, Navy and other government agencies are being supplied.

ENROLMENT FORM FOR PROCUREMENT AND ASSIGNMENT SERVICE FOR PHYSICIANS

Dr. Sam F. Seeley, Executive Officer
Procurement and Assignment Service
New Social Security Building
4th and C Streets S. W.
Washington, D. C.

Dear Doctor Seeley:

Please enroll my name as a physician ready to give service in the Army or Navy of the United States when needed in the current emergency. I will apply to the Corps Area commander in my area when notified by your office of the desirability of such application.

Signed _____

1. Give your name in full, including your full middle name:
2. The date of your birth:
3. The place of your birth:
4. Are you married or single?
5. Have you any children? If so, how many?
6. Do you believe yourself to be physically fit and able to meet the physical standards for the Army and Navy Medical Corps?
7. Have you filled out previously the questionnaire sent to all physicians by the American Medical Association?
8. When and where were you graduated in medicine?
9. In what state are you licensed to practice?
10. Do you now hold any position which might be considered essential to the maintenance of the civilian medical needs of your community? If so, state these appointments:
11. Have you previously applied for entry into the Army or Navy Medical Service? If so, state when, where and with what result (if rejected, state why).

Signature _____

Date _____ Address _____

The Army and Navy Plasma Project

By MAURICE HARDGROVE, M. D.
Milwaukee

THE Surgeons General of the Army and Navy have requested that the American Red Cross in cooperation with the National Research Council procure over 200,000 units of dried human plasma. A unit is the amount of dried powder obtained from the 500 cc. of whole blood obtained from a voluntary donor. Five thousand units are to be obtained as quickly as possible from our Wisconsin district.

The American Red Cross and the National Research Council have completed the National Organization and the work is already under way. The Milwaukee Chapter of the American Red Cross is one of the sixteen chapters taking part in this project.

The local organization consists of an enrollment division and a technical unit. Mrs. Rose is the chapter director of the project under the direction of Mrs. Margaret Sharp, the local chapter executive. Dr. William Egan is the chairman of the Blood Donor Service Committee. The technical supervisor appointed by the National Research Council is Dr. Maurice Hardgrove. Dr. W. W. Busby is the physician in charge of the bleeding unit. The old Academy of Medicine Building, now the National Guard Armory, 507 East Wells, Milwaukee, is to be designated as the Blood Donor Center. Here it is that the donors are enrolled and bled. After the blood is obtained it is shipped to the Abbott Laboratory in North Chicago for separation and drying of the plasma. The dried powder is shipped as rapidly as possible to our troops in combat zones and a supply is available for local disaster. However the hospitals which are making normal liquid serum and plasma, e.g., the Milwaukee Serum Center, Columbia Hospital, are to be encouraged to store large amounts of these substances for local state use.

Under the direction of Mrs. Ralph Immell, other communities throughout the state are to be organized to aid in the collection of blood for the Army and Navy Plasma Project. A mobile unit is being organized at the Milwaukee Procurement Center which will go to other cities for securing blood from large groups of voluntary donors. Physicians are asked to cooperate in securing the enrollment of donors. Voluntary donors are to be found by interesting groups, e.g., church organizations, industrial groups, fraternities, etc., in the project. Sustained interest of such groups will be necessary.

TELEPHONE DIRECTORY LISTING FOR PHYSICIANS IN SERVICE

Members of the State Medical Society of Wisconsin who have entered the armed services of the United States will be interested to know that arrangements may be made with their local telephone offices with reference to maintenance of telephone listings while they are in service. A physician entering the armed services has the following options:

1. He may retain his listing in the alphabetical and classified section of the telephone directory by transferring his business service to his residence at the regular rates for business service.
2. In localities maintaining a physicians' service bureau, listings can be provided so that the calls will be received at the physicians' service bureau providing arrangements have been made by the physician with the physicians' service bureau. The physicians' service bureau can then dispose of the calls or give information to the calling party as directed by the physician.
3. The physician may discontinue his own telephone service and save that expense, and have his name listed under the telephone number of a colleague or some other place of business providing arrangements to answer calls have been made by the physician with any one of these parties.

These listings will be furnished by the telephone company at its regular schedule of rates for such listing service.

County M-Day Chairmen Announced

THE M-Day Committee of the State Medical Society of Wisconsin is composed of Dr. R. E. Fitzgerald, Milwaukee; Dr. J. W. Lambert, Antigo; Dr. R. W. Blumenthal, Milwaukee, and the secretary, ex officio.

Because activities in the field of civilian defense and problems concerned with mobilization have become so extensive, associate members of this committee have been appointed in each county throughout Wisconsin. The appointments were made through the cooperation of councilors and county society presidents.

While the designation of these appointees is that of county M-Day chairmen, the title is by no means descriptive of their responsibilities. Where possible they will assist by participating on the health and welfare committee of the state council for defense and the emergency medical service. M-Day chairmen will cooperate with state committees in the dissemination of information and the obtaining of statistical details on problems pertinent to the national emergency. The committee appointments in each county follow:

Adams
Dr. Harry Shapiro
Adams, Wisconsin

Ashland
Dr. W. J. Tucker
Knight Building
Ashland, Wisconsin

Barron
Dr. L. B. Rydell
Rice Lake, Wisconsin

Bayfield
Dr. J. K. Shumate
Pure Air Sanatorium
Bayfield, Wisconsin

Brown
Dr. A. J. McCarey
305 East Walnut Street
Green Bay, Wisconsin

Buffalo
Dr. E. A. Meili
Cochrane, Wisconsin

Burnett
Dr. L. F. Sherman
Siren, Wisconsin

Calumet
Dr. A. C. Engel
New Holstein, Wisconsin

Chippewa
Dr. J. B. Sazama
Chippewa Falls, Wisconsin

Clark
Dr. A. L. Schemmer
Colby, Wisconsin

Columbia
Dr. A. W. MacGregor
Portage, Wisconsin

Crawford
Dr. E. H. Lechtenberg
Prairie du Chien, Wisconsin

Dane
Dr. C. O. Vingom
122 West Washington Avenue
Madison, Wisconsin

Dodge
Dr. F. C. Bachhuber
Mayville, Wisconsin

Door
Dr. F. C. Huff
Sturgeon Bay, Wisconsin

Douglas
Dr. V. E. Ekblad
1507 Tower Avenue
Superior, Wisconsin

Dunn
Dr. J. A. Halgren
Menomonie, Wisconsin

Eau Claire
Dr. E. L. Mason
131 South Barstow Street
Eau Claire, Wisconsin

Florence–Marinette
Dr. K. G. Pinegar
1723 Main Street
Marinette, Wisconsin

Fond du Lac
Dr. K. K. Borsack
39 South Main Street
Fond du Lac, Wisconsin

Forest
Dr. E. G. Ovitz
Laona, Wisconsin

Grant
Dr. E. M. Houghton
Lancaster, Wisconsin

Green
Dr. J. A. Schindler
Monroe, Wisconsin

Green Lake
Dr. L. J. Seward
Berlin, Wisconsin

Iowa
Dr. T. A. Hagerup
Dodgeville, Wisconsin

Iron
Dr. M. W. Garry
Montreal, Wisconsin

Jackson
Dr. Robert Krohn
Black River Falls, Wisconsin

Jefferson
Dr. J. C. Brewer
Jefferson, Wisconsin

Juneau
Dr. C. A. Vogel
Elroy, Wisconsin

Kenosha
Dr. C. G. Richards
625 Fifty-Seventh Street
Kenosha, Wisconsin

Kewaunee
Dr. Wenzel M. Wochos
Kewaunee, Wisconsin

La Crosse
Dr. George R. Reay
324 Main Street
La Crosse, Wisconsin

Lafayette
Dr. H. F. Hoesley
Shullsburg, Wisconsin

Langlade
Dr. W. P. Curran
Antigo, Wisconsin

Lincoln
Dr. L. J. Bayer
Merrill, Wisconsin

Manitowoc
Dr. E. C. Cary
Reedsville, Wisconsin

Marathon
Dr. Joseph F. Smith
605½ Third Street
Wausau, Wisconsin

Marinette–Florence
Dr. K. G. Pinegar
1723 Main Street
Marinette, Wisconsin

Marquette
Dr. L. V. McNamara
Montello, Wisconsin

Milwaukee
Medical Society of Milwaukee County, Bankers' Building
Milwaukee, Wisconsin

Monroe
Dr. T. J. Sheehy
Tomah, Wisconsin

Oconto
Dr. J. S. Dougherty
Suring, Wisconsin

Oneida
Dr. Marvin Wright
Rhinelander, Wisconsin

Outagamie
Dr. W. J. Frawley
103 West College Avenue
Appleton, Wisconsin

Ozaukee
Dr. A. H. Barr
Port Washington, Wisconsin

Pepin
Dr. L. E. Dickelmann
Durand, Wisconsin

Pierce
Dr. C. A. Dawson
River Falls, Wisconsin

Polk
Dr. L. O. Simenstad
Osceola, Wisconsin

Portage
Dr. E. E. Kidder
Stevens Point, Wisconsin

Price
Dr. J. D. Leahy
Park Falls, Wisconsin

Racine
Dr. E. J. Schneller
744 Main Street
Racine, Wisconsin

Richland
Dr. George Parke
Viola, Wisconsin

Rock
Dr. T. J. Snodgrass
500 West Milwaukee Street
Janesville, Wisconsin

Rusk
Dr. W. F. O'Connor
Ladysmith, Wisconsin

St. Croix
Dr. J. W. Livingstone
Hudson, Wisconsin

Sauk
Dr. Roger Cahoon
Baraboo, Wisconsin

Sawyer
Dr. D. H. Callaghan
Hayward, Wisconsin

Shawano
Dr. A. A. Cantwell
Shawano, Wisconsin

Sheboygan
Dr. F. A. Nause
925 North Eighth Street
Sheboygan, Wisconsin

Taylor
Dr. L. E. Nystrum
Medford, Wisconsin

Trempealeau
Dr. N. S. Simons
Whitehall, Wisconsin

Vernon
Dr. R. S. Hirsch
Viroqua, Wisconsin

Vilas
Dr. R. A. Oldfield
Eagle River, Wisconsin

Walworth
Dr. E. D. Hudson
Lake Geneva, Wisconsin

Washburn
Dr. George Lemmer
Spooner, Wisconsin

Washington
Dr. A. H. Heidner
West Bend, Wisconsin

Waukesha
Dr. H. T. Barnes
Delafield, Wisconsin

Waupaca
Dr. A. M. Christofferson
Waupaca, Wisconsin

Waushara
Dr. A. A. Beck
Wautoma, Wisconsin

Winnebago
Dr. A. G. Koehler
46 Washington Boulevard
Oshkosh, Wisconsin

Wood
Dr. L. A. Copps
Marshfield, Wisconsin
Dr. R. E. Garrison, co-chairman
Wisconsin Rapids, Wisconsin

WISCONSIN COUNCIL OF DEFENSE ORGANIZED

Dr. Neupert Chairman of Section on Health and Welfare

Six divisions of the Wisconsin Council of Defense have been announced by Mr. Ralph Kingsley, Kenosha, chairman. The six divisions include planning, protection, service and facilities, publicity, aviation, and health and welfare. The Health and Welfare Section will function under the direction of Dr. C. N. Neupert, Madison, assistant state health officer. Included under his direction are specific problems in connection with emergency medical service in event of disaster, as well as problems dealing with long-term public health planning, including nutrition, education, consumer interest, nursing, public health, recreation and welfare.

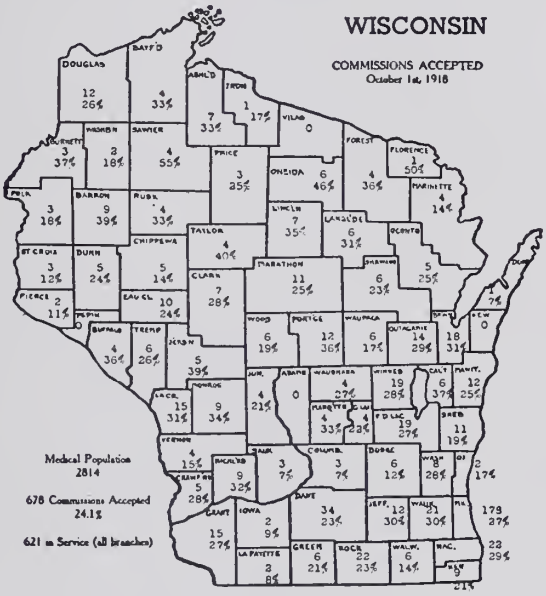
The pattern formulated on the state level for administration of civilian defense will be followed on the county level as each county council of defense is organized.

A Page of Medical History

Wisconsin Medical Journal, October, 1918

ON PAGE 1303 of the December issue of *The Wisconsin Medical Journal*, the State Medical Society published the names of members at the present time in active service in the armed forces of the United States. With the inauguration of this new section entitled "The Nation at War," *The Journal* reproduces, because of their historical interest, three pages from the October, 1918 issue, giving the names of Society members in active service in World War I.

Medical Mobilization and the War



OUR SERVICE FLAG

LIST OF WISCONSIN PHYSICIANS IN SERVICE—OCTOBER 1, 1918

(The following list of physicians in service is as accurate as it is possible to make it from the information at hand in the secretary's office. Kindly send in any corrections you may note which should be made to this list. Undoubtedly, the names of some physicians who are in service have been omitted and it is possible some names have been included of men who are not in service.)

Aaron, Jos., Milwaukee.
Ableman, T. C. H., Watertown.
Ackermann, Wm., Milwaukee.
Adair, J. W., Kenosha.
Adamkiewicz, L. L., Milwaukee.
Ainsworth, H. H., Madison.
Ainsworth, H., Richland Center.
Albers, E. W., Milwaukee.
Allen, E. P., Waukesha.
Allen, J. S., Norwalk.
Allen, L. L. Wauwatosa.
Allen, W. E., Madison.
Anderson, Jens., Racine.
Andre, F. E., Kenosha.
Andrew, G. F., De Sota.
Andrews, C. W., Waupaca.
Andrews, Neil, Oshkosh.
Angell, E. D., Milwaukee.
Aplin, F. W., Waukesha.
Armitage, J. E., Milwaukee.
Axley, A. A., Butternut.
Baasen, J. M., Mt. Calvary.
Bach, R. J., Milwaukee.
Bachman, H. A., Sheboygan.
Bachinski, L. J., Milwaukee.
Badeaux, G. I., Spooner.
Bading, G. A., Milwaukee.
Baer, C. A., Milwaukee.
Bailey, M. A., Fennimore.
Baird, J. C., Eau Claire.
Baker, G. R., Tomahawk.
Baker, W. F., Birnamwood.
Ballard, J. A., Hayward.
Barnes, Edgar, Ripon.
Barnes, H. T., Pewaukee.
Barrett, E. J., Sheboygan.
Barry, H. J., Sun Prairie.
Bassler, H. H., Oshkosh.
Bauer, E. F., Milwaukee.
Bauer, W. W., Milwaukee.
Baun, E. L., Milwaukee.
Bayer, W. H., Gleason.
Bedford, E. W., Sheboygan.
Beebe, C. M., Sparta.
Beeson, H. B., Cornell.
Beffel, J. M., Milwaukee.
Bellis, G. L., Antigo.
Bendixen, B. O., Kewaskum.
Bennett, J. F., Waterford.
Bennett, L. J., Ft. Atkinson.
Bennett, W. C., Rhinelander.
Benson, G., Richland Center.
Bentley, J. E., Portage.
Berger, A. J., New Holstein.
Bickel, E. F., Oshkosh.
Bird, J. W., Stevens Point.
Birkelo, C. C., Rosholt.
Black, N. M., Milwaukee.
Blanton, S. G., Madison.
Blumenthal, R. W., Milwaukee.
Boeckman, F. A., Greenwood.
Boland, J. E., Two Rivers.
Bolton, E. L., Chilton.
Borchardt, A. C., New London.
Borden, F. R., Plainfield.
Boren, J. W., Marinette.
Bowen, R. L., Oshkosh.
Bowman, F. F., Madison.
Boyd, B. F., Kaukauna.
Boyden, W. L., Seymour.
Brazeau, G. N., Racine.
Breeden, R. F., Richland Center.
Brockway, Frank, Oshkosh.
Broghammer, F. J., Superior.
Brook, J. J., Milwaukee.
Brooks, J. T., Minong.
Brown, R. C., Milwaukee.
Brown, G. V. I., Milwaukee.
Bruins, Dirk, Milwaukee.
Brunckhorst, F. O., Hortonville.
Bryant, J. R., Wausau.

A PAGE OF MEDICAL HISTORY, WISCONSIN MEDICAL JOURNAL, OCTOBER, 1918

Buckley, W. E., Hartford.
Buell, H. A., Prairie Farm.
Bundy, H. E., Milwaukee.
Burbach, T. H., Milwaukee.
Burns, H. J., Hudson.
Caldwell, H. C., St. Croix Falls.
Campbell, S., Menomonee Falls.
Campbell, W. B., Menomonee Falls.
Carter, H. M., Madison.
Charbonnau, Arthur, Green Bay.
Christensen, J. W., Sparta.
Clark, W. T., Ft. Atkinson.
Clarke, C. P., Janesville.
Clarke, T. C., Oconto.
Clifford, P. M., Green Bay.
Coleman, Harry, N., Barron.
Combs, C. J., Oshkosh.
Conklin, G. H., Superior.
Conley, J. G., Darlington.
Conley, J. G., Racine.
Conley, J. M., Oshkosh.
Converse, Geo. L., Webster.
Cook, C. S., Evansville.
Cooke, E. P., Milwaukee.
Cooksey, T. R., Madison.
Coon, G. E., Milton Junction.
Cooper, C. A., Norwalk.
Corcoran, C. J., Milwaukee.
Core, W. J., Milwaukee.
Cornwall, W. B., Turtle Lake.
Corr, J. T., Racine.
Cottingham, M. D., Lake Geneva.
Cowan, W. O., Stevens Point.
Cowles, R. L., Green Bay.
Crane, M. C., Osseo.
Christman, E. S., Almena.
Crowe, N. F., Walworth.
Curtain, A. L., Milwaukee.
Cutler, J. S., Wauwatosa.
Cutting, L. D., Stevens Point.
Dallwig, H. G., Milwaukee.
Darby, G. S., Brodhead.
Darling, F. E., Milwaukee.
Darling, H. C., Milwaukee.
Darling, W. G., Milwaukee.
Darling, W. S., Milwaukee.
Davies, R. E., Waukesha.
Davin, C. A., Weyerhauser.
Davin, C. C., New Richmond.
Dawson, Drexel Lowry, Rice Lake.
Dean, J. P., Madison.
Decker, C. O., Candon.
Decker, H. G., Milwaukee.
Dehmel, R. A., S. Germantown.
DelMarcelle, Dr., Neenah.
Devine, C. B., Marshall.
Devine, G. C., Abbotsford.
Dickinson, G. H., Milwaukee.
Doctor, W. R., Cazenovia.
Dockery, E. E., Ripon.
Dockery, Edwin, Green Bay.
Dodge, C. H., Clinton.
Doege, Karl, Jr., Marshfield.
Donnelly, F. J., Nashotah.
Donohue, W. E., Manitowoc.
Doolittle, S. W., Lancaster.
Doyle, J. N., Neshkord.
Drane, R., Madison.
Draper, M. H., Deerfield.
Dreyer, R. A., Wheeler.
Driessel, S. J., Barton.
Drill, A. A., Princeton.
Dudley, L. W., Milwaukee.
DuFrenne, M. F., Sun Prairie.
Durner, U. J., Milwaukee.
Dutton, F. G., Green Bay.
Eastman, J. R., Kenosha.
Ebert, E. C., Milwaukee.
Eck, G. E., Lake Mills.
Edwards, Wm. A., La Crosse.
Egan, Wm. J., Hurley.
Egdahl, A., Menomonie.
Elias, J. F., Milwaukee.
Elliot, R. J., Milwaukee.
Elliott, R. S., Laona.
Elson, J. C., Madison.
Elvis, E. B., Medford.
Erickson, H. C., Stanley.
Evans, C. A., Milwaukee.
Evans, Edward, La Crosse.
Evans, E. P., Milwaukee.
Eyster, J. A., Madison.
Farrell, A. M., Two Rivers.
Faulds, R. C., Abrams.
Farnham, C. R., Milwaukee.
Federman, E. H., Montello.
Ferguson, F. H., Elroy.
Festerling, E. C., Readsville.
Fielder, O. A., Sheboygan.
Fifield, G. W., Janesville.
Finney, W. H., Clintonville.
Fischer, E. H., Milwaukee.
Fitch, R. F., Tomah.
Fitzgerald, G. M., Milwaukee.
Fitzgerald, G. M., Fond du Lac.
Flancher, L. H., Caledonia.
Flancher, L. H., Milwaukee.
Flannagan, G. J., Kaukauna.
Fleming, F. E., Wausau.
Fleming, Wm. J., Milwaukee.
Flynn, L. H., Eau Claire.
Foat, J. S., Ripon.
Foerster, H. R., Milwaukee.
Forkin, W. P., Chilton.
Fortner, W. H., Princeton.
Fosse, B. O., Beloit.
Foster, A. M., Racine.
Foster, A. M., Kaukauna.
Fowler, P. H., Milwaukee.
Fowler, P. H., Plain.
Fowler, J. H., Lancaster.
Fox, P. A., Milwaukee.
France, J. J., Milwaukee.
Frawley, W. J., Appleton.
Frew, J. W., Milwaukee.
Froney, M. A., Racine.
Fuller, C. O., Stratford.
Fulton, H. A., Eau Claire.
Garner, H. L., Rhinelander.
Gates, A. J., Tigerton.
Gates, E., Two Rivers.
Gaterdam, E. A., La Crosse.
Gavin, S. E., Fond du Lac.
Gendron, A. E., River Falls.
Gerend, A., Cato.
Giesen, C. W., Superior.
Gilchrist, R. T., Milwaukee.
Gillespie, W. W., Milwaukee.
Gillette, H. E., Amherst Junction.
Gillette, H. F., Packwaukee.
Gillis, J. D., Antigo.
Gillis, J. P., Deerbrook.
Gosin, D. F., Green Bay.
Gosin, F. J., Green Bay.
Gotsche, E. F., Racine.
Gotterdam, E. A., Milwaukee.
Gramling, H. J., Milwaukee.
Graebner, H. H., Milwaukee.
Grannis, I. V., Menomonie.
Gratiot, W. M., Mineral Point.
Gray, A. W., Milwaukee.
Gray, R. H., La Crosse.
Grisson, C. B., La Crosse.
Griswold, C. M., Alma Center.
Griswold, G. W., Alma Center.
Grosskopf, E. C., Milwaukee.
Grotjan, W. F., Milwaukee.
Ground, H. S., Superior.
Ground, W. E., Superior.
Gunderson, C. A. S., Deerfield.
Gunderson, M. O., Beloit.
Gunther, O. T., Sheboygan.
Hafemeister, E. C., North Prairie.
Hager, F. J., Denmark.
Haggerty, E. E., La Farge.
Hake, Cecil B., Milwaukee.
Hall, B. M., Milwaukee.
Hall, M. W., Mondovi.
Hall, R. M., Milwaukee.
Hanley, W. J., Kenosha.
Halsey, H. A., Hiles.
Haney, F. C., Watertown.
Hansen, J. W., Milwaukee.
Hanson, E. W., Three Lakes.
Hanson, W. C., Racine.
Harding, J., Hudson.
Harkins, J. P., Forest Junction.
Harris, F. M., Fond du Lac.
Harrison, D. C., Mason.
Harrison, Geo. W., Ashland.
Harvie, W. D., Oshkosh.
Harvey, G. R., Footville.
Hayes, E. P., Eau Claire.
Hawley, F. M., Bayfield.
H'Doubler, F. T., Madison.
Hebron, R. A., Cataract.
Hecker, W. H., Beloit.
Hefty, C. A., New Glarus.
Heim, Russell, Marinette.
Heise, H. A., Madison.
Helm, H. M., Beloit.
Hendrickson, H., Green Bay.
Hennig, E. L., Beloit.
Heraty, J. E., Bloomington.
Hinrichs, R. G., Ashland.
Hitz, H. B., Milwaukee.
Hodges, P. C., Madison.
Hoffman, G. H., Milwaukee.
Hoffman, J. G., Hartford.
Hoffman, L. A., Milwaukee.
Hoffman, L. A., Campbellsport.
Hogan, J. H., Racine.
Hogue, G. D., Milwaukee.
Holmes, B. H., Delavan.
Howard, T. J., Milwaukee.
Howell, E. C., Fennimore.
Hudek, D. F., Statesan.
Huff, F. C., Sturgeon Bay.
Hughes, C. W., Winneconne.
Hugo, D. G., Oshkosh.
Hunter, C. M., Stetsonville.
Hutchins, S. E., Whitehall.
Ishmael, O. E., Mt. Horeb.
Ivy, R. M., Milwaukee.
Jackey, F. D., Thorpe.
James, A. W., Muscoda.
Jefferson, H. A., Clintonville.
Jenner, A. G., Milwaukee.
Johnson, A. T., Sauk City.
Johnson, A. W., Milwaukee.
Johnson, C. H., Racine.
Johnson, J. C., Ogdensburg.
Johnston, W. W., Racine.
Jones, M. L., Wausau.
Jones, W. J., Rockland.
Joseph, W. A., Hancock.
Kalling, H., Black River Falls.
Kampmeier, A. J., Milwaukee.
Kay, H. M., Madison.
Kaysen, Ralph, Watertown.
Kaysen, R., Milwaukee.
Keenan, H. A., Stoughton.
Keenan, T. P., Milwaukee.
Kiethley, J. A., Palmyra.
Kelly, C. D., Blair.
Kennedy, F. H., Greenwood.
Kenney, C. J., Milwaukee.
Kenney, G. F., Milwaukee.
Kenney, R. L., Milwaukee.
Kersten, E. M., Two Rivers.
King, Geo. F., Green Bay.
Klein, J. T., Milwaukee.
Knapp, E. J., Rice Lake.
Knox, E. S., Bowler.
Kolls, A. C., La Crosse.
Korthals, F. J., Milwaukee.
Kracow, F. C., Milwaukee.
Krahan, G. W., Oconto Falls.
Kuhn, H. J., Milwaukee.
Kulig, A. H., Dodge.
Kyes, S. M., Owen.
Kyllo, A. L., Grantsburg.
Kyllo, J. C., Superior.
Lademan, O. E., Milwaukee.
Lando, David, Milwaukee.
Lapham, E. A., Rib Lake.
Larson, G. H., Pewaukee.
Lasche, P. G., Richland Center.
Lauder, C. E., Viroqua.
Laughlin, T., Winneconne.
Lawrence, G. H., Fond du Lac.
Lawhorn, C. C., Milwaukee.
Leacy, J. D., Milwaukee.
Leicht, P., Lake Mills.
Leutsker, R., Antigo.
Lewis, P. J., Bloomington.
Lewis, Sherman T., Milwaukee.
Liefert, F. C., Milwaukee.
Lillie, O. R., Milwaukee.
Lindow, G. E., Watertown.
Linkman, E. G., Milwaukee.
Lockhart, C. W., Mellen.
Lockhart, J. W., Oshkosh.
Lohmiller, R. K., Superior.
Longely, J. R., Fond du Lac.
Looze, A. J., Brodhead.
Lorenz, W. F., Mendota.
Loughlin, T. F., Milwaukee.
Ludden, H. D., Mineral Point.
Lynch, D. W., West Bend.
Lynch, H. M., Allenton.
Lyon-Campbell, A. F., Florence.
McBeath, N. E., Livingston.
McCarey, A. J., Green Bay.
McCarthy, H. C., Richland Center.
McCorkle, S. C., Milwaukee.
McCormick, W. C., Tomahawk.
McCoy, H. J., Milwaukee.
McDill, J. R., Milwaukee.
McEachern, W. A., Superior.
McGarty, M. A., La Crosse.
McGinnis, J. E., Green Bay.
McGrath, E. F., Appleton.
McJunkin, F. A., Milwaukee.

A PAGE OF MEDICAL HISTORY, WISCONSIN MEDICAL JOURNAL, OCTOBER, 1918

McKee, E. W., Richland Center.
McLaughlin, F. H., Milwaukee.
McMahon, F. B., Milwaukee.
McNary, J. F., Milwaukee.
McNaughton, W. T., Milwaukee.
McNicholas, L. T., Athens.
MacCormack, R. L., Alma Center.
Mackedon, T. E., Cedarburg.
Madison, J. D., Milwaukee.
Maercklein, O. W., Milwaukee.
Maercklein, A. G., Exeland.
Magill, E. C., Madison.
Majerus, P. J., Sullivan.
Malcolm, J. J., Chetek.
Malkin, G. M., Milwaukee.
Marshall, V. F., Appleton.
Martin, C. D., Milwaukee.
Mason, E. L., Eau Claire.
Maurer, Albert A., La Crosse.
Maurer, H. C., Beloit.
Mecum, J. M., Bagley.
Mehigan, D. D., Milwaukee.
Mehl, H. F., Milwaukee.
Mensing, E. H., Milwaukee.
Merrill, W. G., Grand Rapids.
Mertens, H. G., Bayfield.
Meyer, H. C., La Crosse.
Meyst, C. H., Burlington.
Middleton, W. S., Madison.
Midgley, A. E., Whitewater.
Miller, H. C., Whitewater.
Miller, Thomas, Oconomowoc.
Miller, W. P., Milwaukee.
Minahan, J. J., St. Nazianz.
Minahan, P. R., Fond du Lac.
Mitchell, E. J., Brodhead.
Mitchell, S. R., Milwaukee.
Mitten, A. A., Milwaukee.
Mix, H. C., Green Bay.
Mueller, W. E., Green Bay.
Montgomery, R. C., Madison.
Montgomery, Wm., Eau Claire.
Moore, L. A., Monroe.
Moore, W. N., Appleton.
Moquin, E. I., Fairwater.
Mortell, G. T., Green Bay.
Mountain, J. M., Milwaukee.
Mulsow, J. E., Milwaukee.
Mulsow, J. E., Two Rivers.
Munn, W. A., Janesville.
Murphy, E. R. F., Antigo.
Murphy, W. T., Waukesha.
Myrick, A. L., Eastman.
Nause, F. A., Sheboygan.
Nies, F. P., Gilman.
Niemann, A. C., New Holstein.
Nielsen, G. W., Milwaukee.
Nelson, J. D., Milwaukee.
Nelson, N. O., Madison.
Nelson, O. A., Park Falls.
Nelson, R. N., Horicon.
Newall, F., Burlington.
Nichols, R. M., Sheboygan Falls.
Nims, C. H., Oshkosh.
Nothbohm, D. L. R., Dousman.
Nugent, A. C., Milwaukee.
Nuzum, T. W., Janesville.
Oates, Frank, Fond du Lac.
O'Brien, H. N., Darien.
Oliver, C. H., Boyceville.
Oliver, L. H., Siren.
Olson, Alfred L., Stoughton.
Olson, R. E., Milwaukee.
Oullette, G. J., Oconto.
Palmer, J. A., Arcadia.
Parke, Geo., Viola.
Parker, A. S., Clinton.
Parker, T. G., Rome.
Parmenter, E. L., Mondovi.
Partridge, O. F., Mattoon.
Paulus, D. D., Random Lake.
Pearson, C. M., Ogema.
Pearson, L. M., Tomahawk.
Perry, Gentz, Amery.
Peterson, N. A., Soldiers Grove.
Pfeffer, E. N., Milwaukee.
Pfeifer, E. C., Loyal.
Pfell, R. C., Thiensville.
Phelps, E. J., Elderon.
Phillips, L. J., Weyerhauser.
Pierson, P. R., Readstown.
Pippan, I. B., Excelsior.
Pleyte, A. A., Delafield.
Pollasky, H. D., Milwaukee.
Pomainville, F. X., Grand Rapids.
Pope, F. W., Racine.
Post, C. C., Barron.
Potter, R. P., Marshfield.
Powers, J. W., Burlington.
Powless, Dr., W. DePere.
Pretts, W. M., Platteville.
Prill, H. J., West Salem.
Pullen, A. J., North Fond du Lac.
Quinn, R. B., Darlington.
Randall, A. J., Kenosha.
Rantz, C. B., Weyerhauser.
Rantz, W. L., Rosholt.
Randall, G. R., Milwaukee.
Ravn, E. O., Merrill.
Reay, G. R., La Crosse.
Reddick, G. H., Wabeno.
Redelings, L. H., Marinette.
Rehling, C. F., Fremont.
Reineking, W. C., Wales.
Remer, W. H., Chaseburg.
Reuthin, K. A., Ridgeland.
Richards, C. A., Rhinelander.
Richards, W. M., Platteville.
Riechhoff, G. G., Milwaukee.
Riley, D. B., Milwaukee.
Riley, E. A., Park Falls.
Ripley, H. M., Kenosha.
Roberts, Vernon, National Home.
Robinson, B. N., Prairie du Chien.
Robinson, H. A., Kenosha.
Roby, H. S., Milwaukee.
Rodecker, R. C., Holcombe.
Rogers, P. F., Milwaukee.
Rollefson, C J., Superior.
Rosholt, Jens, La Crosse.
Ross, P. M., Milwaukee.
Rowe, L. B., Brodhead.
Rowley, B. B., White Fish Bay.
Rowley, C. C., Winnebago.
Rueth, J. E., Sun Prairie.
Ruke, E. A., Boscobel.
Ruschaupt, L. F., Milwaukee.
Russell, F. H., Neenah.
Russel, H. C., Milwaukee.
Ryan, E. R., Milwaukee.
Rydell, C. B., Superior.
Salbreiter, W. P., Racine.
Saltzstein, H. C., Milwaukee.
Sanders, A. O., Superior.
Sargent, H. L., Milwaukee.
Saylor, H., Merrill.
Scanlan, P. L., Prairie du Chien.
Scantleton, J. M., Sparta.
Schaefer, C., Racine.
Scheik, I. E., Rhinelander.
Schlaikowski, J. P., Milwaukee.
Schlegel, H. T., Wausau.
Schlenker, G. H., Cazenovia.
Schlesselman, G. H., Fond du Lac.
Schneider, J. F., Oshkosh.
Schnetz, L. N., Racine.
Scholter, E. A., Milwaukee.
Schoofs, O. P., Johnsburg.
Schroeder, E. L., Shawano.
Schubert, F. J., Milwaukee.
Schwarz, S. G., Humbird.
Schwartz, A. B., Milwaukee.
Scott, B. E., Berlin.
Scott, J. C., Marinette.
Scott, J. R., Appleton.
Seaman, G. E., Milwaukee.
Seeger, S. J., Milwaukee.
Seemann, W. O., Eau Claire.
Segal, G. M., Milwaukee.
Senn, C. U., Ripon.
Senn, Geo., DePere.
Senn, Ulrich, Milwaukee.
Sennett, J. F., Milwaukee.
Sexton, W. G., Marshfield.
Sharp, E. L., Plymouth.
Shearer, A. T., Edgerton.
Shearer, F. E., Edgerton.
Shechy, Thos. J., Tomah.
Sheehan, J. R., Milwaukee.
Shimek, A. J., Manitowoc.
Shinnick, T. F., Beloit.
Shippy, V. J. Stevens Point.
Sickels, W. A., Milwaukee.
Simpson, J. E., Endeavor.
Sincock, Henry A., Odanah.
Sisk, I. R., Madison.
Siver, A. W., Milwaukee.
Sieyster, Rock, Waupun.
Smiley, R. B., Stevens Point.
Smith, A. D., Gilmanton.
Smith, C. E., Amherst.
Smith, E. A., Milwaukee.
Smith, Geo. M., Chippewa Falls.
Smith, H. A., Winter.
Smith, J. W., Milwaukee.
Smith, E. W., Madison.
Smith, L. G., Ellsworth.
Smith, S. M. B., Wausau.
Snodgrass, T. J., Janesville.
Sonnenburg, C. N., Sheboygan.
Soudel, L. C., Milwaukee.
Spencer, G. F., Evansville.
Stachle, Max, Manitowoc.
Stamm, L. P., Milwaukee.
Starnes, Brand, Mauston.
Steenburg, H. S., Milwaukee.
Steffen, L. A., Antigo.
Stephenson, W. L., Ladysmith.
Stoland, I., Eau Claire.
Stolz, C. E., Milwaukee.
Stueck, A. F., Milwaukee.
Stueck, A. F., Michicott.
Stuesser, C. N., Oconomowoc.
Sullivan, G. A., Milwaukee.
Sutherland, J., Brodhead.
Sutter, E. H., Milwaukee.
Sykes, L. G., Milwaukee.
Sylvester, H., Montfort.
Taylor, J. G., Milwaukee.
Taylor, F. B., Madison.
Taylor, L. L., Waupun.
Taylor, W. A. Portage.
Tharinger, E. L., Milwaukee.
Thielke, G. A., Wausau.
Thompson, A. S., Mt. Horeb.
Thompson, E. X., Cudahy.
Thompson, F. A., Milwaukee.
Thompson, G. E., Kenosha.
Thompson, J. B., Wittenburg.
Thompson, R. D., Reedsburg.
Thompson, W. J., Portage.
Towle, G. E., Mosinee.
Townsend, D., Oconomowoc.
Townsend, E. H., New Lisbon.
Treglown, L. H., Livingston.
Treichler, M. J., Hancock.
Trock, M. J., Milwaukee.
Trowbridge, P. T., Washburn.
Tuffley, F. S., Boscobel.
Twohig, J. Elmer, Fond du Lac.
Tyvand, J. C., Whitehall.
Van de Erve, Wm., Montello.
Van der Linde, L. A., Wautoma.
Van Heck, D. S., Merrill.
Vankirk, F. W., Janesville.
Vedder, J. B., Marshfield.
Vogel, C. C., Elroy.
Voorus, L. O., Beaver Dam.
Walch, F. C., Black Creek.
Wallschlaeger, G. G., Milwaukee.
Walter, F. A., Stevens Point.
Warfield, L. M., Milwaukee.
Watkins, C. W., Oconto.
Waufle, Guy, Janesville.
Webb, E. P., Beaver Dam.
Weber, A. J., Milwaukee.
Wedge, Athol H., Waupun.
Weingart, Wm., Milwaukee.
Wengleski, J. F., Milwaukee.
Wheatley, C. I., Milwaukee.
White, A. S., Rice Lake.
Whiteside, C. D., Plover.
Whyte, W. F., Madison.
Wilkinson, J. J., Milwaukee.
Wilkinson, M. R., Oconomowoc.
Wilkowski, C. W., Chippewa Falls.
Willett, Thos., West Allis.
Willhite, O. C., Lake Geneva.
Williams, A. E., Eau Claire.
Williams, A. J., Waukesha.
Wilske, Chas. A., Milwaukee.
Wilson, R. S., Milwaukee.
Winneman, W. J., Athens.
Winter, A. E., Tomah.
Witte, D. H., Hartford.
Witte, Dexter H., Milwaukee.
Wolters, H. F., Milwaukee.
Woodhead, F. J., Merten.
Yates, John L., Milwaukee.
Youmans, L. E., Mukwonago.
Ziegler, J. E. B., Eau Claire.
Zuercher, J C., La Crosse.

State-Wide Physicians' Hobby Show

THE Council on Scientific Work announces the first state-wide Physicians' Hobby Show, which will be held in connection with the One Hundred First Anniversary Meeting of this Society in Milwaukee on September 14, 15 and 16, 1942. Dr. Smiles, the member of the Council on Scientific Work who is in charge of this exhibit as well as the scientific exhibits, has set aside an extensive area in the exhibit hall to be devoted to hobbies of our members. Application for exhibit space in the Hobby Show can be made either through Dr. C. J. Smiles, Ashland, or directly through the Society's office in Madison.

Exhibits which have been tentatively reserved for the Hobby Show embrace such subjects as wood working, wood carving, paintings, sketches and etchings; model railroad; stamp collections; metal working and metal spinning; and floriculture. Photographic and firearm exhibits have already been secured for the Hobby Show, and others will be obtained as soon as their existence and nature are made known to the Council on Scientific Work.

Dr. Smiles is most anxious to secure applications from members of the Society for exhibit space at the Hobby Show. An application for such space follows. Mail your application for exhibit space now.

C. J. Smiles, M. D., Director of Scientific Exhibits
State Medical Society of Wisconsin
917 Tenney Building, Madison, Wisconsin
Dear Dr. Smiles:

I wish to make application for exhibit space at the Physicians' Hobby Show to be presented in connection with the One Hundred First Anniversary Meeting of the State Medical Society of Wisconsin.

My hobby exhibit will require _____ lineal feet of space (six feet high).

My exhibit will be on the following subject (subjects):

Bells _____
Books _____
Clay modeling _____
Coins _____
Dishes _____
Documents _____
Etchings _____
Firearms _____
Floriculture _____
Glassware and glass blowing _____
Jewelry _____
Manuscripts _____
Match covers _____
Metal spinning _____
Metal working _____
Model railroads _____
Motion pictures _____
Musical instruments _____

Paintings _____
Prescriptions _____
Sculpture _____
Sketches _____
Soap carving _____
Stamps _____
"Still" photographs _____
Surgical instruments _____
Swords and knives _____
Taxidermy _____
Weaving _____
Wood carving _____
Wood working _____
_____
_____
_____
NAME: _____
ADDRESS: _____

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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Mrs. H. Kent Tenney, Madison

In the Days to Come

By GUNNAR GUNDERSEN, M. D.
President, State Medical Society of Wisconsin

OUR nation, in the tribulation of war, closes its ranks that ultimate victory shall be ours. We, in Wisconsin, as in the nation elsewhere, have a common objective that of necessity gives us a unity of purpose and a singleness of thought,—an objective that dominates interest of self in favor of the interests of our nation.

In the days and months to come, we shall take stock of our physical activities, discarding all but those which truly serve the mighty cause that has become ours within the last month. I need offer no caution that the privilege to serve will be that, as our President has said, of each man, woman, and child who is of our country. To the profession of medicine and to its helpmates, those privileges of service to a country we love will be many and varied. That we shall not be found wanting in character, in ability, or in devotion to our people is an accepted conclusion, for ever in the history of this nation has this been true and it will be true in the days to come.

A truism is that the heart of the nation beats steadily and courageously when supported by good health. The preservation and the protection of the health of the people are the privileges of the medical profession and those who exist to work with and for it, both now and in the future.

Throughout Wisconsin, as indeed throughout all these United States and its territorial possessions, the medical profession is concerned that as war comes closer to the hearts of the people, their needs and emergencies may be met with every facility at the command of the physician and his aides. Detailed planning for the casualties of war have been undertaken over many months by the organization of medicine. Those plans will function as their need develops, but in their functioning the assistance of every member of the Woman's Auxiliary can serve in countless ways in every community, large and small. The physician and his aide have developed, with the national and state headquarters of civilian defense, plans for emergency medical needs. The machinery is perfected. On a moment's notice of its need, it will function effectively and smoothly. May I urge upon each of you, as individuals, the dependency of the country upon you for your assistance and courage.

Finally, I would conclude by offering you the thought that in trial and in perseverance lies the anticipated development of even a greater nation and a greater people that will dedicate its efforts that the people of this world shall live under flags of freedom, and shall be supported by democratic principles of peace and tranquility, that in our day and in the days to come we shall truly live with "Peace on Earth, Good Will to Men."

Mid-Year Meeting of National Board of Directors

By MRS. J. S. SUPERNAW
Madison

THE mid-year meeting of the Board of Directors of the Woman's Auxiliary to the American Medical Association convened on November 14, 1941, at the Palmer House in Chicago with thirty-eight members present.

The report of Mrs. R. E. Mosiman, national president, was an inspiring address with its survey of the work of the Auxiliary and the plans for furthering its aims. Mrs. Mosiman stressed the importance of our work in health defense, particularly in the field of nutrition and the need for a central office for the Auxiliary with permanent secretarial assistance; and suggested the lengthening of tenure of public relations chairmen. This very important office, at every level of our organization, requires not only a thorough knowledge of the program but also the ability and experience for advancing a program of health education through the various mediums available to us.

Dr. W. W. Bauer, director of the Bureau of Health Education of the American Medical Association, spoke briefly on the mechanics of arranging public meetings to insure their success, both for the speaker and the audience, by more thoughtful and detailed planning, and urged more effort on the part of Auxiliary members in reaching groups not ordinarily touched by our public meetings.

Dr. Charles A. Dukes of Oakland, California, vice-president of the American Medical Association, addressed the meeting at luncheon on the Medical Administration Corps. Dr. Arthur W. Booth of Elmira, New York, a member of the Advisory Board to the Woman's Auxiliary, spoke of the increasing need for the work the Auxiliary is doing.

Mrs. Mosiman presented Mrs. V. E. Holcombe of Charleston, West Virginia, past-president of the National Auxiliary, and Mrs. Frank Haggard of San Antonio, Texas, president-elect.

The afternoon session proved very interesting, with the presentation of the reports from the various states of the work being done in the departments of public relations, *Hygeia*, and philanthropy.

After the election of the Nominating Committee, Mrs. Mosiman urged on all of us the need for a sustained and continuing effort in the work of the Woman's Auxiliary and a willingness, as an organized and informed group, to lend increasing aid to the problems of public welfare in our local communities.

IMPORTANT NOTICE

Extra copies of the post-convention issue of the *Bulletin* of the Woman's Auxiliary are available. You may begin your subscription with this issue if you desire. It is an interesting and valuable number, containing four of the major programs of the national organization which have to do with plans for home defense.

It is the plan of the national board to use the official publication to present all important material to the members of the Woman's Auxiliary. All issues of the *Bulletin* will contain, therefore, important programs and articles presenting information necessary for the efficient promotion of our Auxiliary projects.

Subscribers are entitled to four issues of the *Bulletin* for one dollar,—Post-convention, Fall, Spring, and Convention. Please name the issue with which you wish your subscription to start, stating whether it is a renewed or new subscription.

Subscriptions may be obtained from

MRS. CHARLES FIDLER
707 East Wisconsin Avenue
Milwaukee, Wisconsin

or

MRS. CHARLES H. WERNER
2633 Jules Street
St. Joseph, Missouri

Public Relations

By MRS. DEAN H. JEFFERS
Lake Geneva

THE work of the department of public relations is important in many ways. We must promote the distribution to laymen of health information of the American Medical Association. We must learn the needs of the community in order to recommend health projects most useful and likely to be carried out successfully.

An approved definition of the work of a public relations department is "substituting truth for mistaken and distorted conceptions between an impersonal organization and some very personal person." In these days of propaganda devices and confusion caused by the mistaken use of words, we must exercise great care in our efforts to educate laymen through the individuals and organizations of the community interested in health programs.

"One Common Need . . ."

One common need in all communities throughout the United States is a better understanding of nutrition, and it is well for us to stress this as woman's part in home defense. The present limelight on nutrition must not be considered a fad, for a course in it is part of home economics training. A committee in the League of Nations has been working to improve world nutrition through the promotion of better agriculture and distribution and selection of foods. Secretary of Agriculture, Wickard, maintains that the war will be won with food. Others claim food was the cause of Germany losing World War I. The nutrition of the German people then was based on a certain number of calories for each individual, but since then there have been great advances in the science of food and Germany is now using this knowledge to advantage. We must not lag behind in the field of nutrition, and with the abundant food supply in this country there is no need for food regimentation. The question is how to induce people to prepare and eat the right kinds of food.

It has been said that over a third of our people have an inadequate diet. In addition, many others may have sufficient, though not the right kind of food. Nutritional diseases are prevalent among people of ample income as well as among those of low income. Proof of this appears in the number of military rejections and the slowing down of production in industry from loss of time due to low resistance to disease. Surgeon General Parran considers the education of our people to practice good dietary habits for the prevention of nutritional diseases as one of the greatest and most important tasks which the medical profession has before it. This matter of health education is a slow process, but we must not become discouraged. We, as members of the Woman's Auxiliary, can start with our own families, planning daily meals which include the protective foods, thus to increase resistance to disease and to make us more fit for our daily tasks.

"Disseminating Information on Nutrition . . ."

One method of disseminating information on nutrition is through *Hygeia.* We may all have this magazine in our homes, but how many read it and put into practice the suggestions which we know would improve our health? Let us read every number and put into actual practice the nutritional advice given. Pass *Hygeia* on to your friends and relatives, and see that your local school and library are supplied with current copies.

For those who cannot be reached through written word, and they are the greater number, there are the radio and lectures. Publicity should be given to the health programs broadcast by the American Medical Association. Much may also be accomplished by having some well informed speaker deliver a lecture in the community. I suggest you write Dr. W. W. Bauer, director of the Bureau of Health Education of the American Medical Association, 535 North Dearborn Street, Chicago, for dates between

February 15 and March 6, for lectures on nutrition.

Progress is not accomplished by condemnation of wrong food habits. More is gained by constant suggestions and worthwhile results, which prove the benefits of an adequate and proper diet. Food habits are formed in the home, consequently our task is to educate housewives to put into practice the new knowledge of nutrition to bring about improvement in our standards of living. We must be interested and work with greater zest and more patience to help build a nation which is physically, mentally and morally strong.

Work with the Red Cross, stand side by side with men and women who are going forward towards an intelligent and enlightened citizenry for the preservation of our American way of life.

County Auxiliary Proceedings

Dane

The Woman's Auxiliary to the Dane County Medical Society had a luncheon meeting on November 11 at 1 p. m. at the home of Mrs. H. M. Carter, Madison. Thirty-three members and three guests were present. Mrs. J. C. Doolittle, chairman of the luncheon committee, was assisted by Mmes. Sverre Quisling, W. B. Dimond, R. A. Quisling, and L. V. Sprague.

Mrs. H. W. Wirka gave a reading from the book, "Time at her Heels," which was of special interest to the members because it reminded them of their busy days. Miss Katherine Eley sang three songs accompanied by Miss Annabelle Sherer. Miss Katherine Crowley gave a piano solo.

Mrs. Doolittle distributed material for baby gowns to be made for the loan closet and returned at the December meeting. Five dollars was voted upon for the Red Cross.

Mrs. Supernaw, president of the State Auxiliary, reported on her visits to the La Crosse and the Waukesha groups.

The luncheon meeting on December 8 was held at the home of Mrs. W. S. Middleton, Madison. Thirty-six members and two guests were present. Mrs. J. T. Gallagher, chairman of the luncheon committee, was assisted by Mmes. A. R. Curreri, N. A. Hill, D. A. Williams, and W. C. Keettel, Madison.

Miss Emily Wiedenbeck, who writes and illustrates children's books under the pen name of "Peter Mabie," talked on new children's books for Christmas. Christmas music was played on the harp by Betty Jo Tinsman.

Baby gowns made by the members for the loan closet were returned to Mrs. Doolittle. Donations of clothes, especially shoes, were brought for the loan closet. Mrs. Doolittle told how much clothing she had been able to buy for the loan closet with the Auxiliary's $25.

Mrs. Keettel reported that *Hygeia* has been placed in fifty rural schools for the school year.

Mrs. Sprague showed the members the health radio program posters which she is placing in strategic points where the most children and parents will see them.

Dodge

The Woman's Auxiliary to the Dodge County Medical Society held its October meeting at the home of Mrs. J. M. Welsch, Beaver Dam.

The following slate of officers was elected:

President—Mrs. J. M. Welsch, Beaver Dam
President-elect—Mrs. R. E. Schoen, Beaver Dam
Vice-president—Mrs. E. C. Hoyer, Beaver Dam
Secretary—Mrs. R. F. Schoen, Beaver Dam
Treasurer—Mrs. A. W. Hammond, Beaver Dam

It was announced that members of the Auxiliary would motor to Wauwatosa in December to be guests of Mrs. C. M. O'Hora.

Douglas

Eleven members were present at the meeting of the Woman's Auxiliary to the Douglas County Medical Society on December 1 at the Martin Tea Rooms, Superior.

Mrs. George Holtway reviewed the book, "Who Walk Alone," by Perry Burgess. The Auxiliary voted to send flowers to all sick and shut-in members on Christmas morning.

The following slate of officers was elected:

President—Mrs. T. J. Doyle, Superior
President-elect—Mrs. Conrad W. Giesen, Superior
Secretary-treasurer—Mrs. F. G. Johnson, Jr., Superior

The president appointed the following committee chairmen:

Hygeia—Mrs. Fred Proboling, Superior
Telephone—Mrs. Charles W. Giesen, Superior
Public Relations—Mrs. J. C. Kyllo, Superior
Program—Mrs. J. M. Meyers, Superior
Publicity—Mrs. E. A. Myers, Superior

Fond du Lac

Mrs. J. S. Supernaw, president of the Woman's Auxiliary to the State Medical Society, addressed the Fond du Lac Auxiliary on November 27 at the home of Mrs. J. C. Devine, Fond du Lac. Assisting hostesses were Mmes. P. J. Clark, L. C. Gardner, S. E. Gavin, O. F. Guenther, R. L. Dana, and L. J. Keenan. The next meeting will be held on January 22 at the home of Mrs. A. M. Hutter, Fond du Lac.

Kenosha

The Woman's Auxiliary to the Kenosha County Medical Society met on December 9 at the home of Mrs. C. G. Richards, Kenosha. Mrs. W. C. Kleinpell and Mrs. Theodore Sokow were the assisting hostesses. There were twenty-five members present.

Dr. E. F. Andre, president of the Kenosha County Medical Society, spoke on "The History of Medicine," tracing the organization and development of medical knowledge from the earliest beginnings to the present era.

Mrs. G. C. Schulte, Kenosha, *Hygeia* chairman, took subscriptions from members. The Auxiliary voted again to send *Hygeia* to the Orthopedic School, Kenosha Hospital, St. Catherine's Hospital, and Willowbrook Sanatorium.

Mrs. A. J. Randall was appointed chairman to purchase Christmas gifts for the hospitals. It was announced that Kenosha would have a community Christmas project with a life-size creche in the Civic Center and appropriate music and pageantry. The Auxiliary donated about $7 to support this project. It was also voted to send $25 to the Red Cross.

Final plans were made for a tea to celebrate the Centennial Anniversary of the State Medical Society. The meeting concluded with a social hour and gift exchange.

La Crosse

The Woman's Auxiliary to the La Crosse County Medical Society held its December meeting at the Y. W. C. A., on December 1. The hostesses were Mmes. F. A. Douglas, E. H. Townsend, and N. P. Anderson.

Thirteen members were present, and welcome was extended to a new member, Mrs. C. M. Bonniwelle.

Mrs. Joseph Dribben of La Crosse reviewed the book, "That Day Alone," which deals with the importance of preparing for war. Members continued their Red Cross sewing.

Racine

Mrs. G. A. Dockery was hostess at her home in Husher on November 10, to members of the Woman's Auxiliary to the Racine County Medical Society. Her assisting hostesses were Mmes. A. W. Adamski, J. M. Albino, H. G. Brehm, W. E. Buckley, C. F. Browne, and J. C. Docter, all of Racine. For the program Mrs. C. E. Constantine reviewed the book, "The Strange Woman," by Ben Ames Williams, and later Mmes. T. C. Hemmingsen and R. D. Jamieson, both of Racine, poured at tea.

Mrs. E. J. Schneller, Racine, was hostess at the annual *Hygeia* party on November 24 to members of the Racine County Auxiliary and their guests. Twenty tables were set for dessert-bridge, a prize being provided for each table. Fall flowers decorated the rooms of the home, and the Christmas season was suggested with huckleberry bushes in the recreation room, which was decorated in green and white. Assisting hostesses were Mmes. C. L. Kline, K. W. Covell, T. C. Hemmingsen, R. O. Peterson, H. B. Keland, G. N. Gillett and A. L. Nelson, all of Racine.

Twenty members and two guests of the Racine Auxiliary gathered at the DeKoven Foundation, Racine, on December 8 for a luncheon meeting and Christmas party. Participating in the program were Miss Margaret Maxon, pianist, who played Debussy's 'Submerged Cathedral" and John Carre's "Passing Clouds," and Mrs. George Goepfert, who appeared in a reading entitled "The First Gift." Christmas balls and greens decorated the tables at which Mrs. E. W. Schacht, immediate past-president, was presented a bouquet of roses from the group.

Rock

The following list of committee appointees by the president, Mrs. C. R. Gilbertsen, Janesville, supplements the report of the October meeting of the Rock County Auxiliary appearing in the December issue of *The Wisconsin Medical Journal:*

Historian and Parliamentarian—Mrs. V. W. Koch, Janesville
Program, Press and Publicity—Mmes. E. C. Hartman and W. A. Munn, Janesville
Philanthropic—Mmes. G. S. Metcalf and T. J. Snodgrass, Janesville
Public Relations—Mmes. W. T. Clark and W. H. McGuire, Janesville
Hygeia—Mmes. J. F. Kelley, G. W. Bartels and F. C. Binnewies, Janesville
Social and Membership—Mmes. Binnewies and T. W. Nuzum, Janesville

A beautiful memorial, prepared by Mmes. Clark and Gilbertsen, was given for Mrs. F. W. Van Kirk, Janesville.

New officers presided at the meeting of the Rock County Auxiliary held at the home of Mrs. M. E. Ross, Beloit, on November 25. Thirty members were present.

A former Janesville resident, Dr. C. N. Neupert of the State Board of Health, spoke on nutrition. Mrs. J. S. Supernaw, Madison, president of the Woman's Auxiliary to the State Medical Society of Wisconsin, gave an informal talk on legislation. Mrs. Neupert was a guest.

Sheboygan

Members of the Sheboygan County Medical Auxiliary had their Christmas party in the form of a tea at the Guest House, Sheboygan, on December 10. Music during the afternoon was provided by a string quartet comprised of high school students. Mrs. W. G. Meier and Mrs. Alton Schmitt, Sheboygan, poured. Dressed as Santa Claus, Mrs. G. J. Hildebrand distributed the gifts which the auxiliary members had brought to exchange. Later in the afternoon the group did Red Cross sewing.

Walworth

The Walworth County Auxiliary had its first fall meeting on December 9 at the home of Mrs. E. D. Sorenson, Elkhorn. The following officers and committee chairmen will serve for the ensuing year:

President—Mrs. E. D. Sorenson, Elkhorn
President-elect—Mrs. D. H. Jeffers, Lake Geneva
Secretary—Mrs. Walter Mauthe, Whitewater
Treasurer—Mrs. J. A. Rawlins, Elkhorn
Publicity—Mrs. J. D. Warrick, Sharon
Hygeia—Mrs. H. J. Kenney, Delavan
History—Mrs. N. F. Crowe, Delavan

Washington—Ozaukee

The Woman's Auxiliary to the Washington–Ozaukee County Medical Society held its monthly meeting on November 13 at Allenton. Nineteen members and one guest enjoyed the luncheon served by Mrs. George Berger. Following the luncheon the group adjourned to the home of Mrs. R. S. Fisher, Allenton.

Mrs. A. H. Barr of Port Washington submitted the year's program which, after some discussion, was adopted. An article entitled, "Outline of Practical Politics," taken from the *Bulletin* was presented by Mrs. Barr. The article dealt chiefly with the structure of the political party systems, how the parties choose the "planks" for their platforms, and how candidates decide the issues on which to campaign. This is the beginning of a study of medical legislation which the program committee will continue at future meetings.

The program committee members are: Mmes. Barr, Port Washington; C. H. Kalb, Grafton; Daniel Fisher, Fond du Lac; J. E. Reichert, West Bend.

Bridge concluded the activities of the afternoon. Prizes were won by Mmes. W. J. Wehle and J. E. Reichert, both of West Bend, and Mrs. M. E. Monroe of Hartford.

Waukesha

The home of Mrs. D. C. Wilkinson, Oconomowoc, had a festive air on December 3 when eighteen members of the Woman's Auxiliary to the Waukesha County Medical Society gathered for a meeting. Christmas gifts, gaily wrapped, were assembled to be presented to the boys at the Wisconsin Home and Farm School at Dousman.

The main feature of the afternoon was a talk on Christmas decorations by Mrs. David Weart, Oconomowoc. In the business meeting following Mrs. Weart's talk members discussed a change of meeting date, but action was deferred for further consideration.

A dinner was served by the hostesses, the Mmes. D. C. Wilkinson, J. D. Wilkinson, J. B. Noble, and F. J. Woodhead.

Winnebago

Dr. B. J. Hughes, superintendent of the Winnebago State Hospital, addressed the members of the Winnebago County Medical Auxiliary on November 24 at the Hotel Athearn, Oshkosh, giving the first in a series of talks the members will hear on mental hygiene. Dr. Hughes' talk, interesting and instructive, gave a good background for the subject.

Mental illness, he said, should not be regarded as a private or public disgrace to be hidden away as in former years, but should be treated as amenable to treatment or cure. He stressed the magnitude of the problem by telling that 50 per cent of all hospital beds are occupied by the mentally ill. Ninety per cent of the mental hospitals, Dr. Hughes further explained, are publicly controlled, municipal, county, state or federal institutions.

The speaker described Wisconsin's system of primary hospitalization in the central state hospitals at Madison and Winnebago as offering the advantage of early study and diagnosis of all cases with the aim of careful segregation of the incurable cases for custodial care in the county institutions, allowing for concentration on the treatment of those more likely to respond.

The Psychiatric Institute at Madison has been a major factor in the reduction of the number of cases of insanity resulting from syphilis, Dr. Hughes said. The three stages of life during which people appear more susceptible to mental diseases were said to be the period of adolescence, the climactic stage and the twilight time. The institutions of Wisconsin, Dr. Hughes asserted, provide fairly adequate care for the latter two groups, but so far facilities for diagnosis and treatment of mental and behavior problems in adolescents are most inadequate.

With regard to the present emergency, the speaker related, efforts are being made to afford psychiatric examinations to all potential enrollees in the armed forces in order to detect the considerable number of men who under the stress and strain of modern warfare develop manifest psychopathic tendencies and become future public charges.

Auxiliary members also worked at making articles for table decorations at the Winnebago State Hospital.

Society Proceedings

Ashland—Bayfield—Iron

At a meeting of the Ashland–Bayfield–Iron County Medical Society, held on December 19, the following officers were elected for the ensuing year: Dr. C. J. Smiles, Ashland, president and alternate delegate; Dr. J. K. Shumate, Bayfield, vice-president; Dr. R. O. Grigsby, Ashland, secretary and delegate.

Brown—Kewaunee—Door

Forty members of the Brown–Kewaunee–Door County Medical Society were present at a dinner meeting at the Beaumont Hotel, Green Bay, on December 11. Their guest speaker was Dr. J. S. Hirschboeck, associate professor of medicine, Marquette University School of Medicine, who presented a paper entitled "Factors Involved in Pulmonary Embolism."

At a business session the members voted on officers for the ensuing year: Dr. W. E. Leaper, Green Bay, president-elect during 1941, will assume the office of president. Other officers, also of Green Bay, are: Dr. O. W. Saunders, president-elect; Dr. H. S. Atkinson, vice-president; Dr. E. J. O'Brien, secretary–treasurer; Dr. C. J. Chloupek, censor for three years; Drs. P. R. Minahan and O. A. Stiennon, delegates; and Drs. W. W. Kelly and W. E. Leaper, alternate delegates.

Calumet

Dr. Joseph Lettenberger, associate clinical professor of medicine of Marquette University School of Medicine, addressed a joint meeting of the Calumet County Medical Society and the Manitowoc County Medical Society, at a noon luncheon meeting at the Hotel Manitowoc on November 27. The title of Dr. Lettenberger's address was "The Etiology and Treatment of Edema."

Chippewa

Thirty-two members of the Chippewa County Medical Society met at Hotel Northern, Chippewa Falls, for a dinner meeting on December 9. They were addressed by Drs. C. H. Slocumb, assistant professor of medicine, and H. H. Young, instructor in orthopedic surgery, at the Mayo Foundation, Rochester, Minnesota, who spoke on "Medical and Surgical Treatment of Arthritis."

Guests at this meeting were some members from the Eau Claire–Dunn–Pepin County Medical Society and the Barron–Washburn–Sawyer–Burnett County Medical Society.

Columbia—Marquette—Adams

Members of the Columbia–Marquette–Adams County Medical Society held an evening meeting on December 16 at Saint Savior's Hospital, Portage, with eight members present.

At this meeting the president, Dr. H. M. Caldwell, Columbus, appointed a Defense Committee, consisting of Dr. J. W. MacGregor, Portage, chairman; Dr. L. V. McNamara, Montello, and Dr. Harry Shapiro, Adams. The members voted to buy a $600 National Defense Bond with funds available in the treasury.

Dane

The Dane County Medical Society meeting was held at 8 o'clock on December 9 at the Madison Club, with sixty-five members present. The program consisted of two addresses. Dr. H. A. Heise, Milwaukee, had as the subject of his address "How Drunk Am I?" and Mr. N. E. Maloney, district attorney, Madison, discussed "Cooperation Between Law Enforcement Officers and the Medical Profession."

The Board of Trustees of the Society met at 6:15 p. m.

Guests at this meeting included lawyers, judges, city and county police officials.

Dodge

Dr. P. F. Langenfeld, Theresa, was host to the Dodge County Medical Society at a turkey dinner at his home at 6:30 p. m. on December 4. The guest speaker was Dr. J. S. Goodman, Milwaukee, who discussed the subject "Interpretations of Electrocardiograms."

Eau Claire—Dunn—Pepin

Dr. M. W. Wheeler, Saint Paul, Minnesota, addressed the members of the Eau Claire–Dunn–Pepin County Medical Society at their dinner meeting November 24 at the Hotel Eau Claire. The subject of Dr. Wheeler's address was "Recent Aspects in the Treatment of Sinus Disease." Thirty-one members were present at the meeting.

Fond du Lac

Twenty members of the Fond du Lac County Medical Society met November 27 for a 6:30 dinner meeting at Bauer's Hotel, Campbellsport.

The December meeting was held at the Retlaw Hotel, Fond du Lac on the eighteenth. Following a 6:30 dinner, the members enjoyed an address by Dr. A. J. Quick, associate professor of pharmacology at Marquette University School of Medicine, entitled "Clinical Use of Vitamin K."

Eighteen members attended this meeting.

Grant

Members of the Grant County Medical Society held a meeting November 18.

Among other items of business transacted the society voted to sponsor a county-wide clinic for crippled children to be conducted sometime during 1942 at a place to be designated later.

Green Lake—Waushara

The following officers were elected at the December meeting of the Green Lake–Waushara County Medical Society:

Dr. R. C. Darby, Red Granite, president
Dr. S. L. Hadden, Wild Rose, vice-president
Dr. Mildred Stone, Berlin, secretary-treasurer
Dr. J. A. Kelly, Green Lake, delegate
Dr. H. C. Koch, Berlin, alternate delegate

Jefferson

The annual meeting of the Jefferson County Medical Society was held at the Jefferson House, Jefferson, on December 18, at which time members voted on officers for the coming year. Those placed in office were:

Dr. F. A. Wendt, Johnson Creek, president
Dr. F. H. Zimmerman, Watertown, vice-president
Dr. E. A. Schoenecker, Lake Mills, secretary–treasurer
Dr. P. P. Leicht, Lake Mills, censor
Drs. A. C. Nickels, Watertown, and C. J. Garding, Jefferson, auditing committee

Three new members were admitted to the society: Drs. Lester Gallett, Lake Mills; E. E. Burzynski, Watertown; and R. V. Kuhn, Watertown.

Kenosha

The Kenosha County Medical Society held a meeting on November 27, and at that time elected the following officers for the coming year: The office of president will be assumed by Dr. P. E. Pifer, Kenosha. Dr. C. M. Creswell, Kenosha, was elected president-elect; Dr. W. C. Kleinpell, Kenosha, secretary–treasurer; Dr. G. C. Schulte, Kenosha, delegate, and Dr. W. C. Stewart, Kenosha, alternate delegate.

The December meeting included a dinner at the Elks Club, and the guest speaker was Dr. H. K. Nicoll, assistant clinical professor of medicine, Rush Medical College, University of Chicago. The topic of Dr. Nicoll's address was "The Responsibility of the Physician in the Control of Dental Caries."

La Crosse

The regular monthly meeting of the La Crosse County Medical Society was held at the Stoddard Hotel on December 9. Following a 6:30 dinner, a scientific program was presented, with Dr. A. R. Barnes, professor of medicine of the Mayo Foundation, Rochester, as guest speaker. Dr. Barnes spoke on "Problems in the Differential Diagnosis of Coronary Sclerosis."

Manitowoc

Dr. Joseph Lettenberger, associate clinical professor of medicine of Marquette University School of Medicine, addressed a joint meeting of the Manitowoc County Medical Society and the Calumet County Medical Society at a noon luncheon meeting at the Hotel Manitowoc, on November 27, at which members of the Calumet County Medical Society were guests. The title of the address by Dr. Lettenberger was "The Etiology and Treatment of Edema."

Marathon

At a business meeting of the Marathon County Medical Society held on December 16 at the Hotel Wausau, the following members, all from Wausau, were installed as the officers for the coming year:

President—Dr. F. H. Frey
President-elect—Dr. H. R. Fehland
Secretary—Dr. H. H. Fechtner
Treasurer—Dr. R. H. Juers
Legislative and Public Health—Dr. W. C. Frenzel, chairman, Dr. J. M. Freeman, Dr. G. H. Stevens
Program Committee—Dr. F. C. Prehn, chairman, Dr. A. H. Stahmer, Dr. H. H. Christensen
Board of Censors—Dr. P. Z. Reist, chairman, Dr. D. M. Green, Dr. J. K. Trumbo

The remainder of the meeting was devoted to routine business.

Marinette—Florence

At a recent meeting members of the Marinette–Florence County Medical Society held election of officers and named the following as officers for the coming year:

Dr. J. V. May, Marinette, president
Dr. C. H. Boren, Marinette, vice-president
Dr. K. G. Pinegar, Marinette, secretary–treasurer
Dr. A. T. Nadeau, Marinette, delegate
Dr. H. W. Haasl, Peshtigo, alternate delegate

Milwaukee

The annual meeting of the Medical Society of Milwaukee County was held December 11 in the Crystal Ballroom at the Hotel Schroeder, commencing with a dinner at 6:15 p. m. The program was opened by remarks by the retiring president, Dr. T. J. Howard, assistant clinical professor of medicine, Marquette University School of Medicine. The guest speaker was Dr. Creighton Barker, assistant clinical professor of otolaryngology, Yale Univer-

sity School of Medicine, whose address was entitled "The Doctor in Wonderland."

Following election of officers the incoming president, Dr. C. W. Eberbach, Milwaukee, addressed the group.

The officers elected for the coming year are:

Dr. E. J. Carey, dean of Marquette University School of Medicine, president-elect; Dr. M. A. Hardgrove, Milwaukee, secretary; Dr. F. C. Heidner, Milwaukee, treasurer; Dr. T. J. Howard, the retiring president, director for a five-year term; Drs. P. E. Oberbreckling and John McCabe, censors for two-year terms.

Outagamie

The Outagamie County Medical Society held its regular monthly meeting at the Conway Hotel, Appleton, at 6:30 p. m., November 27. They had as their guest speaker Dr. H. C. Slocum, instructor in anesthesia, University of Wisconsin Medical School, who discussed "Physiology of Respiration".

At a business meeting the following were elected to office for the coming year:

Dr. C. A. Pardee, Appleton, president
Dr. G. M. LaCroix, Shiocton, vice-president
Dr. D. M. Gallaher, Appleton, secretary–treasurer
Dr. G. W. Carlson, Appleton, delegate
Dr. D. W. Curtin, Little Chute, alternate delegate
Dr. S. A. Konz, Appleton, censor

The December meeting included a dinner at the Conway Hotel on the eighteenth, at which the wives of the doctors were guests. The group heard an address by Dr. Paul Anderson of Lawrence College on "Our American Philosophy."

Pierce—St. Croix

Dr. A. E. McMahon, Menomonie, secretary of the Pierce–St. Croix County Medical Society, reports that the following officers were elected on October 23 to serve during 1942:

Dr. C. A. Olson, Hammond, president
Dr. Chalmer Davee, River Falls, vice-president
Dr. A. E. McMahon, Menomonie, secretary–treasurer and delegate
Dr. Julius Blom, Woodville, censor for three year term
Dr. O. H. Epley, New Richmond, alternate delegate

The December meeting of the Pierce–St. Croix County Medical Society was held at Hudson on the eighteenth. At the business meeting the questionnaire of the State Medical Society's Committee on Nursing Problems was discussed, as well as the National Youth Administration program, the National Physicians Committee, and examination of draftees.

Following the business meeting Mr. George B. Larson, acting secretary of the Society, presented the film strip "Health Achievements in Wisconsin." Mr. Larson outlined to the members of the county medical society the origin of the Committee on Health and Public Instruction's film and stated that the committee recommended that it be used by physicians in addressing parent–teacher associations, women's clubs, service organizations such as the Rotary, Kiwanis, or Lions, and other groups.

At the conclusion of the presentation the members of the Pierce–St. Croix County Medical Society indicated that they planned a series of lectures in each of the communities where this film might be shown to advantage.

Portage

Members of the Portage County Medical Society, at their meeting on December 3, elected the following officers, all of Stevens Point, for the next year:

Dr. H. P. Benn, president
Dr. S. R. Miller, vice-president
Dr. R. J. Stollenwerk, secretary–treasurer and alternate delegate
Dr. W. F. Cowan, censor
Dr. F. A. Marrs, censor
Dr. A. G. Dunn, censor
Dr. E. E. Kidder, delegate

Racine

The Racine County Medical Society meeting was held at the Elks Club, Racine, on November 27. The scientific program consisted of a lecture by Dr. C. J. Newcomb, Milwaukee, entitled "Perineal Forceps", and an illustrated lecture by Dr. J. B. De Lee, professor of obstetrics and gynecology at the University of Chicago School of Medicine, entitled "Eclampsia and its Treatment."

At a business meeting the following, all of Racine, were elected to office:

Dr. R. J. Schacht, president
Dr. W. E. Buckley, president-elect
Dr. G. W. Walter, vice-president
Dr. Beatrice O. Jones, secretary–treasurer
Dr. T. C. Hemmingsen, delegate
Dr. E. J. Schneller, alternate
Drs. E. W. Schacht, H. G. Brehm, and O. W. Pfeiffer, executive board members

The December 18 meeting included a dinner at the Hotel Racine. Following installation of the new president, members heard an address by Dr. J. P. Nesselrod of Evanston, Illinois, entitled "Proctoscopic Color Photography."

Richland

At a meeting of the Richland County Medical Society on December 18, the following officers were elected for 1942:

Dr. George Parke, Jr., Richland Center, president
Dr. H. A. Settlage, Lone Rock, vice-president
Dr. G. H. Benson, Richland Center, secretary and alternate delegate
Dr. George Parke, Viola, delegate

On December 10 Dr. B. I. Pippin, Richland Center, councilor from the fourth district, entertained 107 guests at the Park Hotel. Guests included all the physicians from the fourth councilor district; Dr. Gunnar Gundersen, La Crosse, president of the State Medical Society; Dr. S. E. Gavin, Fond du Lac; Dr. W. T. Clark, Janesville; Dr. J. W. Lambert, Antigo; Assemblyman Donald McDowell, Soldiers Grove; Senator Jesse Miller, Richland Center; and members of the Richland County Dental Society.

Dr. R. F. Boyd, Milwaukee, Mr. J. F. Machotak and Mr. R. H. Pohlman, representatives of the Farm Security Administration, presented the medical problems of their clients at the business meeting.

Also at this meeting there was discussion concerning the filling of the vacancy created by the death of the secretary of the State Medical Society, Mr. J. G. Crownhart.

Rock

Dr. W. S. Middleton, professor of medicine and dean of the University of Wisconsin Medical School, addressed members of the Rock County Medical Society at their dinner meeting in the Hotel Hilton, Beloit on November 25. The title of Dr. Middleton's address was "Therapeutic Experiences." Sixty-five members attended.

The December meeting of the Society was held at Hotel Monterey, Janesville, on the sixteenth. At this meeting Dr. M. G. Peterman, Milwaukee, gave an illustrated lecture on "Preventive Pediatrics in General Practice."

The January meeting will be held at Hotel Hilton, Beloit, at 6:30 p. m., on January 27, and the principal speaker will be Dr. P. C. Kronfeld, medical director of the Illinois Eye and Ear Infirmary, who will speak on "Five Years at the Pekin Medical College".

Rusk

Dr. M. L. Whalen, Bruce, secretary of the Rusk County Medical Society, reported the following officers had been elected for 1942: Dr. W. F. O'Connor, Ladysmith, president; Dr. M. L. Whalen, Bruce, secretary; Dr. L. M. Lundmark, Ladysmith, delegate, and Dr. Woodruff Smith, Ladysmith, alternate delegate.

Sheboygan

A regular meeting of the Sheboygan County Medical Society was held at Sheboygan Memorial Hospital on December 9 at 8:15 p. m. The speaker of the evening was Dr. H. M. Weber, instructor in radiology at the Mayo Foundation, Rochester, who discussed "The Use of X-ray in the Determination of the Causes of Obscure Gastro-intestinal Bleeding." Approximately forty members were in attendance.

At the annual election of officers the following members were placed in office:

Dr. C. M. Yoran, Plymouth, president
Dr. A. J. Schmitt, Sheboygan, vice-president
Dr. W. G. Huibregtse, Sheboygan, secretary–treasurer
Dr. C. J. Weber, Sheboygan, delegate
Dr. A. C. Radloff, Plymouth, alternate delegate
Dr. G. H. Stannard, Sheboygan, censor

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society held its annual meeting at the MacCornack Clinic, Whitehall, on November 27, and had as its guest speaker Dr. R. L. Parker, instructor in medicine, Mayo Foundation, Rochester, who discussed "Coronary Heart Disease." About thirty members and guests attended. The meeting at the Clinic was preceded by a dinner at the Erickson Hotel.

Election of officers at a business meeting placed the following in office:

Dr. F. T. Younker, Galesville, president
Dr. B. C. Dockendorff, Arcadia, president-elect
Dr. R. L. Alvarez, Galesville, secretary–treasurer
Dr. R. L. MacCornack, Whitehall, delegate
Dr. Robert Krohn, Black River Falls, alternate delegate

Walworth

Members of the Walworth County Medical Society, at a recent meeting, elected the following officers for 1942:

Dr. T. J. Kroyer, Walworth, president
Dr. S. G. Meany, East Troy, vice-president
Dr. M. G. Helmbrecht, Elkhorn, secretary–treasurer
Dr. E. D. Sorenson, Elkhorn, delegate
Dr. D. H. Jeffers, Lake Geneva, alternate delegate

Washington—Ozaukee

The following officers were elected for the year 1942 by members of the Washington–Ozaukee County Medical Society on November 27:

Dr. O. W. Hurth, Cedarburg, president
Dr. R. S. Fisher, Allenton, vice-president
Dr. K. F. Prefontaine, Slinger, secretary
Dr. J. G. Hoffmann, Hartford, delegate
Dr. O. J. Hurth, Cedarburg, alternate delegate
Dr. M. E. Monroe, Hartford, censor

Waupaca

Fourteen members of the Waupaca County Medical Society attended a dinner meeting at the Elwood Hotel, New London, on December 16 and enjoyed an address by Dr. C. D. Neidhold, Appleton, entitled "Health Achievements in Wisconsin." This included the showing of a film prepared by the State Medical Society.

Winnebago

Dr. K. E. Lemmer, associate professor of surgery at the University of Wisconsin Medical School, addressed the members of the Winnebago County Medical Society at their dinner meeting at the Athearn Hotel, Oshkosh on December 4. The topic of his address was "Recent Advances in Gall Bladder Disease."

At a business session, the members elected officers for the coming year. Named as president of the society was Dr. M. C. Haines, Oshkosh. Other officers to serve with him are: Dr. V. G. Springer, Omro, vice-president; Dr. E. F. Cummings, Oshkosh, secretary–treasurer; Dr. R. A. Jensen, Menasha, delegate; and Dr. A. G. Koehler, Oshkosh, alternate delegate.

First Councilor District

The First Councilor District meeting was held at the Elks Club, Watertown, on November 25 at 3 p. m. The clinical program consisted of a symposium on the "Acute Abdomen" presented by the following: Dr. O. O. Meyer, associate professor of medicine, and Dr. J. W. Harris, professor of obstetrics and gynecology, at the University of Wisconsin Medical School, and Dr. J. P. Dean, head of the Department of Surgery, Saint Mary's Hospital, Madison.

Following the clinical program members held a business meeting with election of officers.

A 6:30 dinner was served, after which members were entertained by Orenda with his magic tricks.

Third and Eleventh Councilor Districts

Dr. C. J. Baumann, Milwaukee, president of the Wisconsin State Dental Society, addressed members of the Third and Eleventh Councilor Districts at a meeting at the Conway Hotel, Appleton, on November 29.

Also on the program were a clinic on prosthetic dentistry presented by Dr. O. M. Dresen of Marquette University School of Dentistry and a demonstrated lecture on the proper technique of dental radiography by A. W. Bradison of Marquette University.

Central Wisconsin Society of Ophthalmology and Otolaryngology

Following is the program presented to members of the Central Wisconsin Society of Ophthalmology and Otolaryngology at their two day meeting at Marinette on November 29 and 30:

Saturday, November 29

6:30 p. m. Dinner at Hotel Marinette.

"Acute Suppurations of the Throat, Mouth and Cervical Regions"—Dr. A. C. Furstenberg, dean and professor of otolaryngology, University of Michigan Medical School, Ann Arbor.

"Some Ocular Manifestations in Diseases of the Nervous System"—Dr. F. B. Fralick, professor of Ophthalmology, University of Michigan Medical School, Ann Arbor.

Sunday, November 30

9:00 a. m. "A Review of Glaucoma Cases"—Dr. E. E. Neff, associate professor of ophthalmology, University of Wisconsin Medical School.

"The Cross Cylinder as used in Refraction"—Dr. F. B. Fralick.

"Nasal Accessory Sinus Disease. Its Diagnosis and Treatment"—Dr. A. C. Furstenberg.

Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine meeting was held at the Milwaukee University Club on December 9. The meeting opened with a 6:30 dinner, which was followed by a business session at eight o'clock and a scientific program. Dr. W. H. Studley, Milwaukee, lectured on "The Recognition of the Potential Suicide," and Dr. C. P. Huber, assistant professor of obstetrics at the Indiana University School of Medicine, discussed "Risks in Obstetrics."

Milwaukee Neuro-Psychiatric Society

Members of the Milwaukee Neuro–Psychiatric Society held a dinner meeting on November 27 at the Milwaukee Sanitarium, Wauwatosa, after which the following program was presented to them:

"Constitutional Aesthenia"—Dr. C. W. Osgood

"Effect of Electroshock on Chemically Induced Cataleptic States"—Dr. Lawrence Kolb

"Patients' Reactions to Death in Family"—Dr. M. Q. Howard

"Masculine–Feminine Factors in Patients"—Dr. B. A. Ruskin

"Rare Neurologic Syndromes I Have Seen"—Dr. L. H. Ziegler

Milwaukee Oto-Ophthalmic Society

A dinner meeting was held by the members of the Milwaukee Oto-Ophthalmic Society on December 9 at the University Club. Following dinner a clinical meeting (presentation of cases) was conducted. Dr. P. A. Halper, Chicago, was the guest speaker. The topic of his address was "The Cross Cylinder in Ophthalmology."

Milwaukee Pediatric Society

The annual meeting of the Milwaukee Pediatric Society was held on December 10 at the Milwaukee Athletic Club. The newly elected officers for 1942 are: Dr. J. H. Reynolds, president; Dr. B. J. Malnekoff, vice-president; and Dr. F. J. Mellencamp, secretary–treasurer.

Milwaukee Society of Clinical Surgery

Members of the Milwaukee Society of Clinical Surgery met at the University Club on November 25 for a dinner meeting. Dr. R. G. Carothers, Cincinnati, addressed the group on "Fracture of the Neck of the Femur—Technique of Pinning with Analysis of Bad Results." Dr. W. M. Kearns, Milwaukee, also presented a lecture on "Recumbent Calculi."

News Items and Personals

Tremendous advances in the science and practice of medicine during the twenty-five years of the existence of the Marshfield Clinic were described by prominent medical men as that organization observed its silver anniversary with a program and dinner at St. Joseph's School of Nursing, Marshfield, on December 18.

Approximately ninety physicians from Wisconsin communities near Marshfield and as far distant as Ashland, Appleton, Madison, and La Crosse, attended the dinner, which climaxed three days of special events commemorating the golden anniversary of St. Joseph's Hospital, the enlargement of its School of Nursing, and the Marshfield Clinic's silver anniversary.

The speakers on the evening program were *Dr. Gunnar Gundersen*, La Crosse, president of the State Medical Society of Wisconsin; *Dr. W. S. Middleton*, Madison, dean of the University of Wisconsin Medical School, and Dr. G. S. Sutherland, Mayo Clinic roentgenologist and librarian of the Radiological Society of North America. *Dr. P. F. Doege* of the Marshfield Clinic staff, as well as Dr. Sutherland, were speakers on the afternoon program, which was followed by inspection of the St. Joseph's School of Nursing.

Dr. W. G. Sexton, president of the Clinic staff, acted as toastmaster and welcomed the guests to the double anniversary observance. He expressed regret that three of the six founders of the Clinic, *Drs. V. A. Mason, H. H. Milbee*, and *K. W. Doege* could not have lived to take part in the jubilee observance.

Dr. Gundersen, in discussing "Medical Practice in Wisconsin," lauded the late *Dr. Doege* and a number of other early Wisconsin physicians as belonging to a school of pioneers skilled in general and specialized surgery, and discussed the vast progress made during the last twenty-five years in such fields as thoracic, orthopedic, and neurologic surgery, anesthesia, and medical aids to surgery.

Dr. Middleton, medical instructor of many of the doctors present, in discussing "Twenty-Five Years of Medicine," described the national scene in 1891 and 1916, when Hospital and Clinic were founded, and also told of tremendous medical advances made in the years the two institutions have been functioning. He stressed the importance of present day laboratory work in diagnosis and predicted that "medicine is so dynamic a subject that we may find greater development in the next twenty-five years than in the last twenty-five years."

Dr. Sutherland, in discussing "X-ray: Past, Present, and Future," gave a history of the x-ray from its discovery by Roentgen and described recent developments in this field. *Dr. P. F. Doege* discussed diagnosis and treatment in his address entitled "Carcinoma of the Colon."

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Dr. W. H. Remer has retired from his practice at Chaseburg. For thirty-seven years he has been actively engaged in the practice of medicine, thirty years of which have been spent in Vernon County. *Dr.* and Mrs. *Remer* will henceforth divide their time between La Crosse and the lake region of Park Falls.

Dr. Remer was active in the Vernon County Medical Society and the Tri-County Medical Society, which includes members from Monroe, Juneau and Vernon Counties. Simultaneously with his retirement *Dr. Remer* resigned from the presidencies of both societies, which he had held for many years.

Succeeding *Dr. Remer* in his practice at Chaseburg will be *Dr. J. R. Richter*, who for the last year and a half has practiced medicine at Waunakee. *Dr.* and Mrs. *Richter* will occupy the former home and office of *Dr. Remer*.

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Dr. E. L. Sevringhaus, professor of medicine at the University of Wisconsin Medical School, addressed a meeting of fathers and sons, sponsored by the Lions Club, at Sun Prairie on November 27. *Dr. Sevringhaus* spoke on "The Anatomy and Normal Changes in the Human Body."

—△—

Dr. S. R. Beatty, Oshkosh radiologist, speaking at the weekly luncheon meeting of the Rotary Club in Oshkosh, discussed the science of roentgenology and radiology. He explained that radiology is the more general science of radiations and diagnosis through them, while roentgenology is the more narrow science of using x-rays. He also related the discovery of x-ray in 1895 by Wilhelm Konrad von Roentgen, German physicist, stating that its medical application was almost immediate and the progress of its development very rapid.

Dr. E. A. Pohle, professor of radiology at the University of Wisconsin Medical School, was a speaker at the annual meeting of the Michigan Association of Roentgenologists held in Detroit early in December. The topic of his address was "The Treatment of Intra-oral Carcinoma."

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Dr. Harold E. Fillbach, Cuba City, took the Woods–Gillespie postgraduate course in refraction at La Salle, Illinois, November 30 to December 6.

—△—

Dr. E. J. Carey, dean of Marquette University School of Medicine, represented Milwaukee at the annual medical meeting of the National Foundation for Infantile Paralysis in New York City the first week in December.

—△—

Dr. H. L. Miller, Milwaukee, was certified by the American Board of Dermatology and Syphilology following its meeting held in New York on December 13.

—△—

Dr. K. F. Prefontaine has been appointed health officer for the village of Slinger and also holds that position for the village of Polk.

—△—

At a recent joint meeting of the Walworth County Hospital staff, *Dr. N. F. Crowe*, Delavan, was elected president; *Dr. W. H. MacDonald*, Lake Geneva, vice-president, and *Dr. M. G. Helmbrecht*, Elkhorn, secretary-treasurer.

—△—

Dr. E. V. Stadel, Reedsburg, has been named physician for the Sauk County Home and Asylum. He succeeds *Dr. Otto Sporleder*, who resigned to take over a practice at La Farge.

—△—

Dr. J. C. Sargent, clinical professor of urology at the Marquette University School of Medicine, who is a past-president of the State Medical Society of Wisconsin and delegate to the American Medical Association, spoke to Kiwanis Club members at Cedarburg on December 1. He discussed ethics in medicine, and traced the beginning of medicine from 500 B. C., when Hippocrates, who has been called the "Father of Medicine," transformed the ancient rites administered to the sick to a basis of present scientific knowledge.

—△—

Dr. M. H. Seevers, associate professor of pharmacology at the University of Wisconsin Medical School, addressed members of Alpha Omega Alpha, at a luncheon meeting at the Memorial Union, December 13. *Dr. Seevers* spoke on the sociological and medical aspects of addiction, stressing morphinism.

—△—

Dr. D. A. Cleveland, associate clinical professor of neurological surgery and assistant professor of anatomy, Marquette University School of Medicine, has been added to the medical advisory staff of the Milwaukee Fire Department, raising the number of men on the staff to eleven.

Dr. W. H. Drissen has been re-appointed for another year as county health officer at Port Washington.

—△—

Dr. A. R. Tormey, Madison, will succeed the late Mr. William J. Wandrey as a director of the National Guardian Life Insurance Company in Madison.

—△—

Dr. S. A. McCormick, Madison, has been named acting superintendent of the Verona County Home and Asylum until a permanent appointment can be made.

—△—

Dr. E. A. Habeck, Milwaukee, was re-elected president of the staff of Evangelical Deaconess Hospital at the annual staff meeting on December 2. Other officers elected for 1942 were *Dr. T. J. Aylward*, vice-president, and *Dr. C. L. Wirthwein*, secretary.

—△—

Dr. K. P. Hoel, superintendent of the Oak Sanatorium at Pewaukee, using as his theme "Christmas Seals," spoke at the Shady Nook Parent-Teachers Association meeting at West Allis, on December 19.

—△—

Dr. E. K. Steinkopff, Milwaukee, gave an illustrated address before the Parent-Teachers Association at Hudson on November 17. He outlined the needs and benefits of preventive medicine, stating that the prevention of disease includes such measures as clinics, quarantine laws, and publicity and education, and such cooperative activities as cleanliness both of person and premises, staying at home when suffering from colds, and submitting to vaccination against contagious diseases.

—△—

Dr. C. L. Newberry, Milwaukee, has been appointed to the medical service division of the Federal Farm Security Administration. He will work on the Atlantic seaboard, arranging medical services for farm families.

—△—

Included on the program of the Wisconsin Board of County Judges annual meeting on December 4 and 5, were *Dr. H. M. Coon*, superintendent of the State of Wisconsin General Hospital, and *Dr. B. J. Hughes*, superintendent of the Winnebago State Hospital.

—△—

Dr. W. M. Sonnenburg, Sheboygan, was re-elected county physician by the Sheboygan County Board of Supervisors on November 25. He has served in this capacity for the past twelve years.

—△—

Dr. E. C. Cary, Reedsville, was re-elected president of Marquette Medical Alumni Association for the fourth time on December 5, at Milwaukee.

—△—

Dr. J. C. Docter, Racine, was elected chief of the medical staff at St. Mary's Hospital at the annual meeting in December. Others elected were *Dr. R. J. Schacht*, vice-president; and *Dr. R. M. Kurten*, secretary-treasurer.

CORRESPONDENCE

December 19, 1941

Mr. George B. Larson, Acting Secretary
The State Medical Society of Wisconsin
917 Tenney Building
Madison, Wisconsin

Dear George:

The December issue of *The Wisconsin Medical Journal* has come to my desk, and I notice that the Blue Book is included in this copy. It has been my feeling for a long time that the Blue Book is one of the fine things that the State Medical Society has been making available for the benefit of the medical man in the State of Wisconsin. I am sure that, in a great many cases, it will save the doctor more than the cost of his State Medical Society dues.

Also, I take pleasure in glancing through the advertisements from time to time because, knowing the standards that are used in determining the type of advertising that is taken, it gives one a clue to reliable information.

With best wishes to you for the New Year, and kindest regards,

Very sincerely,
ERWIN R. SCHMIDT, M. D.
Madison, Wisconsin.

December 22, 1941

Mr. George B. Larson, Acting Secretary
State Medical Society of Wisconsin
917 Tenney Building
Madison, Wisconsin

Dear Mr. Larson:

The December Medical Blue Book is worthy of attention. From the index through the advertising section, there one may find all the answers to all the perplexing questions before one has a chance to ask them. The detailed information is not only necessary but protective of the physician's interests.

The pamphlet "Health Achievements in Wisconsin" contains tangible as well as unified information. I am very glad to have my copy.

With the Season's greetings, I remain

Very truly yours,
GAIL R. BROBERG, M. D.
Neenah, Wisconsin.

READABLE WRITING

Employes of the Bureau of Vital Statistics of the State Board of Health have become handwriting experts in their ability to provide certified copies of birth and death certificates in this state. For many years, copies of vital statistics records have been furnished in hand-copied form by members of that division.

However, new social security laws and the complexity of the entire field of national defense have resulted in the Bureau of Vital Statistics' receiving an unprecedented number of requests for copies of these records. The requests have been so numerous and so urgent that the Bureau has been forced to provide this service through a microfilm process, both for ease of filing and rapidity of service.

Copies of vital statistics will now be made by a process similar to that used in making up the drivers' licenses, so those requesting certified copies of these records now will be provided with an actual photographic reproduction of the original. No longer will the handwriting expert of the bureau be called upon to decipher or interpret these records. Physicians will often be confronted with a photographic duplicate of the original form of these documents, and they are cautioned by the State Board of Health to make a special effort to fill in the blank forms legibly.

SOCIETY RECORDS

New Members

D. V. Moen, Shell Lake.

R. H. Gunderson, Fairbanks Morse & Company, Beloit.

R. C. Love, Glenwood City.

Edward Palmer, Hillsboro.

K. B. Appleby, 747 North Twenty-seventh Street, Milwaukee.

J. M. Regan, 611 North Eighteenth Street, Milwaukee.

J. J. Gaunt, 1411 North Sixtieth Street, Milwaukee.

E. J. Jelenchick, 230 West Madison Street, Milwaukee.

C. R. Eichenberger, 5841 West Bluemound Road, Milwaukee.

Changes in Address

C. A. Kelly, Dresser Junction, to St. Croix Falls.

L. H. Gueldner, Camp Bowie, Tex., to Fort Atkinson.

Otto Sporleder, Reedsburg, to La Farge.

Elizabeth R. Baldwin, Hartland, to 832 Roslyn Circle, Highland Park, Ill.

M. T. Mitchell, Fort Sam Houston, Tex., to Fitzsimmons General Hospital, Denver, Colo.

P. E. Wright, Wisconsin Rapids, to 9 South Eighth Street, Manitowoc.

R. J. Dalton, Fifield, to Box M. M. Cristobal, Canal Zone.

W. H. Remer, Chaseburg, to 424 South Eleventh Street, La Crosse.

J. R. Richter, Waunakee, to Chaseburg.

A. F. Rogers, Carlisle, Pa., to Fort McClellan, Ala.

J. P. Malec, Camp Forrest, Tenn., to Army Air Training School, Chanute Field, Ill.

BIRTHS

A son to Dr. and Mrs. H. D. Grota, Sturgeon Bay, December 16.

A son to Dr. and Mrs. A. L. Reinardy, Stevens Point, on December 16.

A son, James Francis, to Mr. and Mrs. James O. Kelly, Milwaukee, on December 29. Mr. Kelly is the executive secretary of the Medical Society of Milwaukee County.

MARRIAGES

Dr. Warren T. Hagerty, Green Bay, and Miss Evangeline M. Penegore, Greenland, Mich., on November 19.

DEATHS

Dr. Truman E. Loope, Iola, died at his home on December 6, at the age of 71.

Dr. Loope was born May 23, 1870, at Eureka, Wisconsin. He was graduated from the University of Wisconsin in 1891 and entered Rush Medical College in Chicago for the study of medicine, graduating in 1894. His first practice of medicine was at Horicon, and later at Bessemer, Michigan, where he had charge of a hospital. He came back to Wisconsin, however, and opened a practice at Manawa, where he remained until he returned to Bessemer in 1897 to assist his brother who was superintendent of the Bessemer Hospital. A year later he returned to Manawa for a year and then moved to Iola, where he remained until his death.

Although Dr. Loope became blind in 1928, he continued some of his practice for several years thereafter. Dr. Loope was a member of the first University of Wisconsin football team in 1889.

Dr. Loope also served his community in an official capacity. He was trustee of the village of Iola from 1901 to 1905 and from 1912 to 1916; president from 1906 to 1908, and health officer for one year in 1926. Except for a six year interim, he was a director on the Iola School Board from 1903 to 1938. He was a former president of the Waupaca County Medical Society.

Surviving him are four children, Dorothy Loope, R. N., of Polacca, Arizona; Mrs. John Kline of Akron, Ohio; and James and Richard of Milwaukee; one sister, Mrs. John Stanton of Eureka; and a granddaughter, Jane Loope.

Dr. Charles H. Stoddard, Milwaukee, died at his home on December 17, at the age of 72.

Dr. Stoddard was born in East Troy, Wisconsin. After he was graduated from the University of Wisconsin, he studied medicine at the University of Illinois College of Medicine and graduated in 1892. He served his internship at Michael Reese Hospital in Chicago, after which he studied at Vienna, Austria and Strassburg, Germany. On his return to the United States, he practiced medicine for a short time at Colton, California, and in 1894 began his practice in Milwaukee.

Dr. Stoddard was well known for his extensive work against tuberculosis. He served on the first commission organized by the Medical Society of Milwaukee County to fight tuberculosis and was a member of the board of directors of the Wisconsin Anti-Tuberculosis Association when it was founded in 1909, serving as its vice-president from 1925 to 1930, president from 1931 to 1932, and recording secretary from 1933 until his death. When the Bluemound Preventorium, later incorporated with Muirdale, was established, Dr. Stoddard was named first medical director and superintendent.

He was a member of the Medical Society of Milwaukee County, the State Medical Society, the American Medical Association, the American College of Physicians, and the Milwaukee Academy of Medicine. He was a former president of the Medical Society of Milwaukee County and the Milwaukee Academy of Medicine. During the World War he served as a major in the medical corps of the Wisconsin National Guard.

Surviving are his widow and two sons, Charles H. Jr. of Milwaukee, and Dr. Frederick J. of Ann Arbor, Michigan.

Dr. William F. Zierath, Sheboygan, died at his home after a lengthy illness, on December 5, at the age of 64.

Dr. Zierath was born in Manitowoc in 1877. When he was five years old his parents moved to Sheboygan. He attended the elementary and secondary schools in Sheboygan, and studied medicine at Northwestern University Medical School, graduating in 1904. After his internship at Wesley Hospital in Chicago he returned to Sheboygan where he began his medical career, which he maintained until his death.

He is survived by his widow; a son, Captain Fred Zierath, now stationed in the Hawaiian Islands; three daughters, Mrs. Walter Osterhoudt of Houston, Texas, Mrs. Gerald L. Sirks of Riverside, California, and Marion at home.

Dr. Frank C. Walch, Clintonville, died on December 9, at a Milwaukee hospital, at the age of 57. He had been ill for several months.

Dr. Walch was born in Seymour, Wisconsin on January 11, 1883, and received his elementary and secondary education there. He studied medicine at the Milwaukee Physicians and Surgeons College in Milwaukee, now Marquette University School of Medicine. After his graduation in 1907, he practiced medicine at Black Creek, until he enlisted in the medical corps during the World War and served overseas. Following the World War he returned to Black Creek and resumed his medical practice there. In 1923 he moved to Clintonville, and had maintained his medical practice there until his illness several months ago.

A hobby Dr. Walch had pursued for approximately twenty-five years was studying the pyramids. He had delivered many lectures on this subject, the favorite among which was the one entitled "Great Pyramids, It's Divine Message."

Dr. Walch took great interest in the public welfare of his community and was instrumental in reviving the American Legion there. He was also active in masonic circles.

Surviving Dr. Walch, besides his widow, are a daughter, Mrs. L. A. Larson, Wauwatosa, and two brothers, Andrew, of Manawa and Fred, of Vesper.

Coming Events

University of Wisconsin Medical School Schedule of Saturday Morning Clinics

Jan. 17. Neuropsychiatry: Common Types of Psychiatric Disorders with Reference to Psychiatric Therapy. Dr. Lorenz and Dr. Pessin

Jan. 24. Urology: Discussion of Common Malignant Tumors Involving the Organs of the Genito-Urinary Tract. Dr. Sisk and Associates

Jan. 31. Medicine: Clinical Problems in Pituitary-Gonadal Relationship. Dr. Sevringhaus and Associates

Feb. 7. Pediatrics: Hyperthyroidism in Childhood. Dr. Gonce and Associates

Feb. 14. Surgery: Gallbladder Surgery and Hepatorenal Syndrome. Dr. Gale and Associates

Feb. 21. Obstetrics and Gynecology: Carcinoma of the Uterus—Prophylaxis, Diagnosis and Treatment. Dr. Campbell and Associates

Feb. 28. Medicine: Sigmoidoscopic and Radiologic Correlation in Diagnosis and Treatment of Colonic Disorders. Dr. Puestow and Associates

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Milwaukee County Hospital Interne's Association

The Milwaukee County Hospital Interne's Association has announced that its next meeting will be held on January 31, 1942.

Milwaukee Children's Hospital Schedule of Clinical Presentations

Surgical clinics—Mondays

Orthopedic and fracture clinics—Tuesdays

Pediatric clinics—Fridays

Time: 12:30 to 1:30 p. m.

JANUARY, 1942

Pediatric Clinic—Friday, January 16
The Grid Chart for Evaluating the Nutritional and Growth Status of Children. Discussion by W. W. Busby, M. D., L. Schaefer, M. D., and Miss Clausen, Milwaukee.

Surgical Clinic—Monday, January 19
Presentation of cases. Discussion of Osteomyelitis.

Orthopedic and Fracture Clinic—Tuesday, January 20
No clinic.

Pediatric Clinic—Friday, January 23
Treatment of Common Skin Diseases in Children. Discussion by S. M. Markson, M. D., Milwaukee.

Surgical Clinic—Monday, January 26
Presentation of cases. Discussion of Wringer Injuries.

Orthopedic and Fracture Clinic—Tuesday, January 27
No clinic.

Pediatric Clinic—Friday, January 30
The Value and Interpretation of Neurologic Signs and Tests in Pediatrics, i.e., Nystagmus, Unequal Pupils, etc. Discussion by John L. Garvey, M. D., Milwaukee.

(Continued on page 82)

A New Year — An Old Code

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COMING EVENTS—Continued

FRIDAY MORNING CLINICS—1942

Milwaukee County Hospital and the Marquette University School of Medicine

Milwaukee, Wis.

February 6
1. The medical management of portal cirrhosis.
2. Liver insufficiency and gall bladder surgery.

February 13
1. Mediastinal tumors.
2. Shoulder injuries.

February 20
1. Mediastinal tumors.
2. Treatment of esophageal strictures.

February 27
1. Treatment of syphilis and its complications.
2. Obstetrical subject.

March 6
1. Tetanus.
2. Modern concepts in treatment of wounds.

March 13
1. Recent advances in radiology.

March 20
1. The risk of minor surgery in the hypertensive and nephritic patient.
2. Recent advances in treatment of burns.

March 27
1. Diarrhea in infancy.
2. Treatment of hypertrophic pyloric stenosis.

April 3
No clinic.

April 10
1. Uncommon causes of heart disease.
2. Eye injuries.

April 17
1. Practical aspects of physiotherapy.

April 24
1. Pleural effusion.
2. Chest injuries.

—△—

Examinations—American Board of Obstetrics and Gynecology

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted at Atlantic City, N. J., by the entire Board, prior to the opening of the annual meeting of the American Medical Association in Atlantic City, on June 8, 1942.

Application for admission to Group A, Part II, examinations must be on file in the secretary's office not later than March 1, 1942. It will greatly facilitate the work of the Board if applications are filed as far as possible in advance of the closing date for their receipt.

Formal notice of the time and place of these examinations will be sent each candidate several weeks in advance of the examination dates.

Candidates for *reexamination* in Part II must make written application to the secretary's office before April 15, 1942.

As previously announced in the Board booklet, this fiscal year (1941–1942) of the Board marks the close of the two groups of classification of applicants for examination. Thereafter, the Board will have only one classification of candidates, and all will be required to take the Part I examinations.

The Board requests that all prospective candidates who plan to submit applications in the near future request and use the new application form which has this year been inaugurated by the Board. The secretary will be glad to furnish these forms upon request, together with information regarding Board requirements. Address Dr. Paul Titus, secretary, 1015 Highland Building, Pittsburgh, Pa.

CHRISTENSEN—BUTTER IN NATIONAL HEALTH

(Continued from page 52)

Research workers began work on the problem and obtained evidence that this factor exists, and so far tests have not shown its presence anywhere except in animal fats. At this time experiments are being made to isolate and identify the factor, and after that more tests will determine its source and what quantities of it are needed for normal growth. Deficiency in what the scientists now call the "butterfat growth factor" shows its greatest effect in newborn animals. The new growth factor is no known compound, but is some new type of saturated fatty acid, the presence of which encourages normal growth and development, and a deficiency of which results in poor health and stunted growth.

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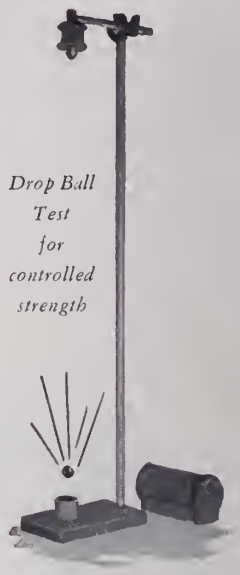

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How to Use MEAD'S *Vacap-Dropper*

Remove both top and side caps. Wipe dropper tip. Place forefinger firmly over top opening and regulate rate of flow by varying the degree of pressure. Oleum Percomorphum is best measured into the child's tomato juice. This is just as convenient and much safer than dropping the oil directly into the baby's mouth, a practice which may provoke a coughing spasm.

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MEDICINE—Two Weeks Intensive Course will be offered starting June 1st. Two Weeks Course in Gastro-Enterology will be offered starting June 15th. One Month Course in Electrocardiography and Heart Disease every month, except December and August.
FRACTURES & TRAUMATIC SURGERY—Two Weeks Intensive Course will be offered starting March 9th. Informal Course available every week.
GYNECOLOGY—Two Weeks Intensive Course will be offered starting April 6th. Clinical and Diagnostic Courses every week.
OBSTETRICS—Two Weeks Intensive Course will be offered starting April 20th. Informal Course every week.
OTOLARYNGOLOGY—Two Weeks Intensive Course will be offered starting April 6th. Clinical and Special Courses starting every week.
OPHTHALMOLOGY—Two Weeks Intensive Course will be offered starting April 20th. Five Weeks Course in Refraction Methods starting March 9th. Informal Course every week.
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Bruckner, Die Biochemie des Tabaks, 1936
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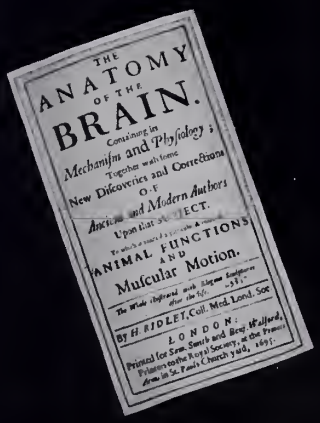

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1. Council Report: J.A.M.A., 113: 1734, 1939
2. Merritt, H. H. & Putnam, T. J.: A. J. Psychiat., 96: 1023, 1940

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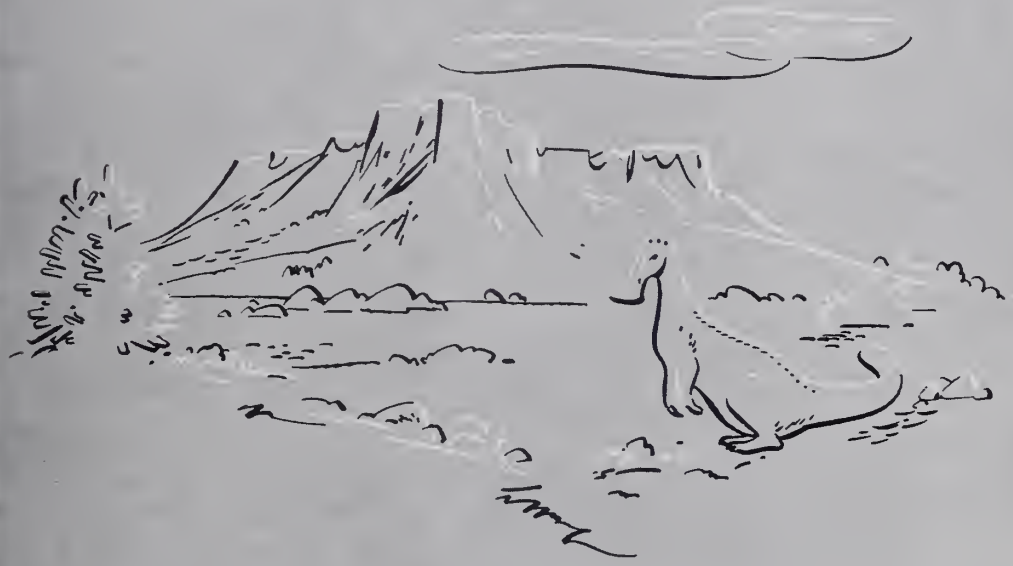

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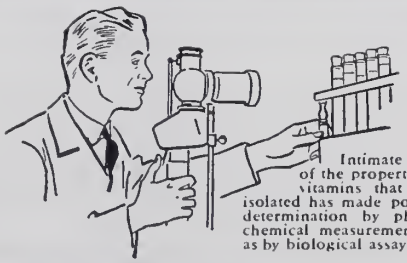

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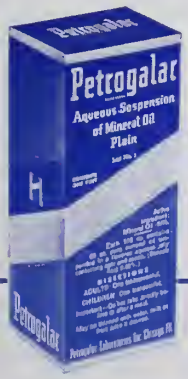

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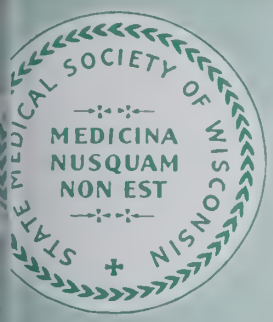

The Wisconsin Medical Journal

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MANAGEMENT OF ENDOCERVICITIS
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THE NATION AT WAR

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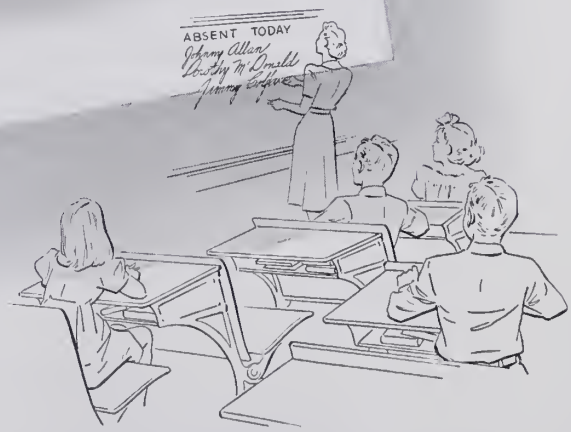

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[Entered as second class matter, June 30th, 1903, at the Post Office at Milwaukee, Wis., under Act of Congress March 3rd, 1879. Transferred to Madison, Aug. 1st, 1929.]
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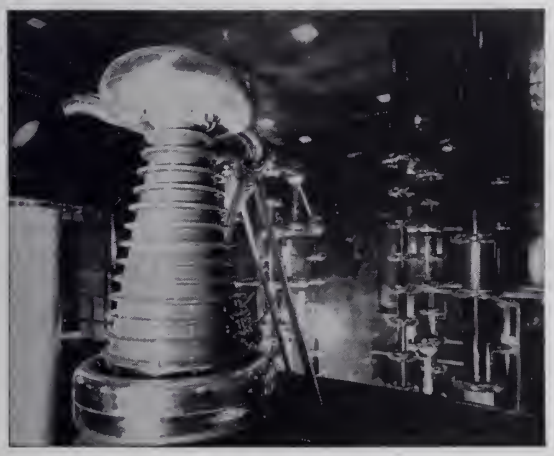

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THE WISCONSIN MEDICAL JOURNAL

VOLUME 41, NO. 2 Copyright, 1942, by The State Medical Society of Wisconsin FEBRUARY, 1942

Drugs in Intractable Pain*

By M. H. SEEVERS, Ph. D., M. D.**

Madison

THE current interest in specific chemotherapy may tend to detract attention from the fact that even if every pathogenic organism which invades the human host were to be brought under absolute control, the alleviation of pain is, and always will be, a major consideration of the physician. It behooves us, therefore, to understand in so far as is possible the characteristics of pain and the effects of pain on the functional activity of various body organs, as well as the reaction pattern of the patient to the pain experience. Without this knowledge the rational use of analgesic drugs is not possible.

In order to crystallize our thinking on this subject I would like to point out that there are five strategic points in the pain mechanism toward which the physician may direct his attack. The tactical approach will be modified naturally by the specific problems presented in each individual patient.

1. Abolition of the Peripheral Pain Stimulus

It would insult your intelligence to dwell on the fact that the most logical method of relieving pain is to eliminate or modify the pain stimulus whenever this is possible. Obviously it is beyond the scope of this brief to consider the possibilities along these lines. To do so would be to recount all of the measures designed to eliminate the stimulus whether it originates from physical, mechanical, or chemical irritation, smooth muscle or vascular spasm, inflammation, neuritis, or any other source. This aspect of the problem should not be minimized, however, and it is the primary concern of the physician to search out the origin of pain and remove it, if possible, before resorting to more drastic measures.

2. Blockade of Pain Pathways

Advances in technical methods and neurologic knowledge have increased greatly the ease of accomplishment and the effectiveness of temporary or permanent block of nerve trunks, dorsal roots, or pain tracts in the cord, hind- or midbrain areas. Whereas this field is the domain of the specialist, and time prevents elaboration here, the general practitioner should be acutely aware of the possibilities along these lines. Very often a few cubic centimeters of procaine or alcohol or the stroke of a knife in the hands of an expert may relieve pain where all other methods are without avail.

3. Elevation of the Pain Threshold

The only means available at the present time to alter the pain threshold is to administer drugs which are capable of reducing the activity of those centers in the brain which are concerned with pain perception. This class of drugs is subject to sufficient misuse that it shall be my purpose to delineate certain principles which underlie their rational administration.

The ideal analgesic drug would be one which is capable of specifically abolishing the perception of pain without exerting any significant effect on perception of other stimuli or altering mental acuity. In so far as they

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* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

** On February 1, 1942, Dr. Seevers, associate professor of pharmacology at the University of Wisconsin, assumed the position of professor of pharmacology at the University of Michigan.

are effective analgesics, the coal tar derivatives (aminopyrine and the like) and the salicylates, and more recently cobra venom, fulfill these requirements better than any other known compounds. Their ineffectiveness in most types of severe pain lies in the fact that they are incapable of inducing a great elevation of the pain threshold or in modifying the reaction pattern to pain, even in maximal dosage. Their analgesic effect as antirheumatics is in all probability due in part to a peripheral action in abolishing the source of pain.

A much greater increase in the pain threshold is obtained with the opium alkaloids, alcohol, and subanesthetic concentrations of the gaseous narcotics. With these drugs the elevation of the pain threshold is accompanied by a simultaneous reduction in psychic activity, a factor which is commonly desirable but under other circumstances definitely limits their usefulness.

Since morphine and its congeners are the most important class of drugs at our disposal for the relief of severe pain, they may be discussed as type compounds. Recent observations in our laboratory,[1] confirmed and extended by Wolff and his collaborators,[2] have furnished data which should be useful as part of the working knowledge of every physician. These studies involved the application of graded pain stimuli of different types to normal human subjects before and after administration of the different commonly used opiates in varying dosage. Certain generalizations can be drawn from these studies.

The threshold-raising action of the opiates is in part dissociable from the stupefying action of these drugs. In other words, a marked increase in the pain threshold may be obtained without the necessity of inducing a lethargic state. This point is important clinically since it will lead us to try smaller doses of the opiates and depend less on how the patient appears than whether he is relieved of his pain. The establishment of this fact also encourages us to continue the search for drugs which specifically will modify pain perception.

The threshold-raising action is related quantitatively to the size of the dose with smaller quantities of these drugs but does not hold for larger amounts. With doses below 15 mg. (gr. ¼) of morphine, the relation between dosage and analgesic action is a straight line function. With doses in excess of 15 mg., some increase occurs but the proportionality no longer holds. In fact, 30 mg. (gr. ½) of morphine produces the maximum elevation of the pain threshold which may be obtained in the normal individual with this drug. If this is termed a 100 per cent threshold-raising action, then 15 mg. (gr. ¼) produces a 70 per cent increase in the threshold. Quantities of morphine in excess of 30 mg. may abolish pain by inducing unconsciousness or by prolonging the threshold-raising effect but do not increase further the threshold.

With codeine the greatest threshold-raising action obtainable is effected by 60 mg. of this drug. In comparison with morphine this maximum is only 50 per cent above the control threshold. Increasing the dose to 120 mg. (gr. 2) does not elevate the threshold or even prolong the effect significantly. Even when 60 mg. of codeine is administered at 80 minute intervals no further increase above the 50 per cent level is obtainable. It may therefore be stated categorically that codeine in any dosage will never be more than 50 per cent as effective as morphine in raising the pain threshold.

The threshold-raising action of the opiates is reduced or may be completely abolished by pain. A pre-existing and uniform pain stimulus has a greater neutralizing effect on the action of the opiates than when pain is induced or occurs just prior to, or during, the action of the drug. Thus, as is known from common clinical experience, individuals in very severe pain will tolerate much larger doses of these drugs; in fact, the increase is necessary if the pain threshold is to be raised. This is unfortunate since the degree of acquired tolerance to these compounds is directly proportional to the rate of increment in dosage. Likewise, the degree of physical dependence, and consequently the intensity of the symptoms and signs of with-

drawal, are proportional to the total amount of the drugs administered. Obviously then, the greater danger of addiction is present in the individual with the most intractable pain since more of the drug is necessary to control his pain. It should be appreciated also that a large quantity of morphine administered to an individual to control an acute and intense pain of short duration will subsequently exert a profound and possibly toxic action when the pain stimulus subsides or is removed.

The administration of epinephrine prior to the injection of morphine is like pain in that it neutralizes the threshold-raising action. It is quite possible that these actions have a common basis. It is well established that pain, fear, apprehension, panic, etc. do cause a hypersecretion of the adrenal glands. Furthermore, all of these factors render a patient more difficult to depress with the opiates or, in fact, with any other narcotic substance.

The peak of threshold-raising action with moderate doses of the opiates occurs between 30 and 90 minutes. Due to greater rapidity of absorption from subcutaneous areas the peak is reached somewhat more rapidly with codeine and heroin than with morphine or dilaudid. With larger doses the peak action occurs at 60 to 120 minutes, although effective analgesia against lesser grades of pain may be present within 15 minutes.

The duration of threshold-raising action is more of a function of the total dosage of the drugs, presumably due to more prolonged and constant absorption. The total duration of threshold-raising action of 15 mg. of morphine is between 6 and 8 hours. This does not mean that effective analgesia will be obtained against all grades of pain during this time. The nature of the curve is such that peak analgesia is maintained only a proportional part of this total period. For example, if pain was of such a grade as to demand a 50 per cent elevation of the pain threshold to abolish it, effective analgesia would be obtained for 3 hours only, that is, during the second, third and fourth hours of its action, whereas a more severe grade of pain, sufficient to require a 65 per cent increase above the control level, would be abolished for only 1 hour, that is between the ninetieth and one hundred fiftieth minute.

With 15 mg. of morphine it is necessary to repeat the drug every 3 to 4 hours to maintain a reasonable threshold-raising action, whereas with codeine 60 mg. every 90 to 120 minutes is required to accomplish a similar effect. With dilaudid the threshold-raising action is somewhat less prolonged but more intense than morphine, rendering it necessary to repeat at 3 hour intervals. One mg. (gr. 1/60) of dilaudid is equivalent in threshold-raising action to 10 mg. (gr. 1/6) of morphine. It is thus possible to obtain pain relief with this compound with quantities of the drug below that ordinarily recommended and by so doing reduce the

Opium Alkaloid	Equivalent Analgesic Subcutaneous Doses	Time Necessary for Peak Analgesia After:		Descending Order of Potency* after Subcutaneous Administration Regarding:			Untoward Side-effects*
		Subcut. Admin.	Intrav. Admin.	Duration of Analgesic Action	Duration and Intensity of Subjective Depression	Euphoria	
	milligrams	minutes	minutes				
Morphine sulfate	10	60—90	20	1	1	2	1
Heroin hydrochloride	1.0—2.0	30	20	4	3	1	4
Dilaudid hydrochloride	0.8—1.0	90	20	2	2	3	2
Codeine phosphate	64	30—60	20	3	4	4	3

* Order of Potency: 1=most; 4=least.

amount of lethargy which would accompany the administration of larger amounts.

The peak of threshold-raising action is reached in approximately 20 minutes after the *intravenous* administration of any of the commonly used opiates, although the peak of narcotic or stupefying action is obtained within 2 to 3 minutes. The patient suffering acute and intolerable pain should be given the benefit of this method of administration. The method is safe providing dilute solutions are administered slowly.

The *duration* of action following intravenous administration is significantly less than when the same quantity is administered subcutaneously or intramuscularly. This is due to the immediate onset of detoxification which is now known to be largely by urinary excretion.

4. Modification of the Reaction Pattern to Pain

As has been pointed out clearly by Wolff and his co-workers, numerous situations exist in which pain perception may be dissociated from the usual pattern of reaction to the pain experience; for example, the indifference to pain often experienced during play or combat, sexual excitement, parturition, or in religious practices. *Under these circumstances pain is perceived but the usual reaction, anxiety, fear, panic, flight or fight, is not forthcoming.*

The opiates possess better than any other class of drugs the capacity to alter the pattern of reaction to pain. This quality of the opiates is difficult to quantitate, but it is well known that these effects precede and outlast the threshold-raising action of these drugs. During the course of the action of an opiate a sharp pain stimulus may exceed even the elevated pain threshold, but the anxiety and apprehension which would accompany such an event ordinarily are abolished or greatly diminished. It should be pointed out that alcohol possesses this quality in some degree but larger doses are required. This quality is not possessed by most other depressants such as the barbiturates or the aliphatic hypnotics. It is this property, in addition to the threshold-raising action, which renders the opiates so effective.

Scopolamine has no effect on the pain threshold. Nevertheless, it does modify the reaction pattern and thereby reduces the psychic trauma associated with the pain experience. It is especially useful in enhancing this most valuable action of the opiates.

5. Induction of Stupefaction, Sleep or Anesthesia

Relief of pain obtained by modification of the reaction pattern as just discussed is not identical with the relief of pain obtained from the stupefying action of a drug. In the former instance, pain is perceived but the patient does not react to it. In the latter, analgesia is obtained in so far as the patient is rendered unable to perceive pain, whether this be by inducing intense lethargy, sleep or anesthesia. For example, the barbiturates and the aliphatic hypnotics induce extreme lethargy and reduce mental acuity even more than the opiates, but may fail to relieve anxiety or alter the pain threshold.

Since sleep alone elevates the pain threshold approximately 50 per cent, the barbiturates may be effective against lesser grades of pain only in so far as they induce sleep or unconsciousness. They do not possess to any significant degree the specific property of modifying pain perception if given in hypnotic doses. They may be useful in mild or moderate pain as adjuvants to other compounds which specifically elevate the pain threshold, such as the salicylates. A very undesirable type of reaction may be obtained with the barbiturates if the pain stimulus is intense. Even when the dosage is adequate to induce unconsciousness a reflex motor response may result from a sudden or even a constant pain stimulus. With a dose which is just sufficient to carry the patient to the borderline of consciousness, any painful stimulus may evoke an exaggerated reaction pattern of flight or fight, since cerebral inhibitions are removed but the pain threshold has not been altered. Morphine is the only compound which will control this type of reaction, but it is necessary to emphasize the fact that the summative depressant action of these two drugs on respiration is often undesirable.

In closing, I should like to emphasize that since the perception of pain is subjective, the reaction pattern will be modified greatly by the pre-existing psychic state of the individual. In a real sense, therefore, the complete control of pain becomes a psychologic and psychiatric problem as well as one involving the materia medica.

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Management of Endocervicitis*

By T. K. BROWN, M. D.**

St. Louis

IN THE light of present knowledge, it seems logical and advisable to consider cervicitis and vaginitis as very closely related diseases. Roblee[1] speaks of the condition as "cervicitis–vaginitis syndrome." Should one of these conditions be treated without regard for the other, recurrence of symptoms will very likely result. The most common symptom is discharge. In order to treat cases rationally one must pause and consider the normal physiology of the cervical and vaginal secretions and then note any deviations.

It is readily possible to determine the pH of the cervical and vaginal discharges by the use of Nitrazine papers (Squibb) and an accompanying color chart. A bright yellow indicates a pH 4.5 and a dark blue, a pH 7.5. The normal reaction of the vagina should be pH 4.0 to 4.5 and of the cervix, pH 7.0 to 7.5. A chart produced by Karnaky[2] illustrates the conditions present from birth to the senile state. It is normal to have Doederlein bacilli present in goodly number. Desquamated epithelial cells on smear and the ability of the mucous membrane to stain deeply with Lugol's solution indicate normal presence and action of estrogens. Pus cells should be few in number or absent.

As to etiology, the following types must be considered:

1. Bacterial
   Specific—gonococcal
   Non-specific—usually anaerobic
2. Trichomonas
3. Yeast
4. Monilia—thrush
5. Amoebae
6. Endocrine

Bourne[3] and Bond[4] in commenting on the last type of cervicitis, noted the lack of evidence of any bacterial action as the causative factor and suggested an abnormal hormonal mechanism. I quote, "This picture makes it difficult to believe that infection can be present deep in the glands of the canal, since, were pathogenic organisms there, they must surely give some evidence of their presence in the shape of an inflammatory reaction in the adjacent tissues; on the other hand, the very superficial distribution of that inflammation which is present, i.e. in the erosion, cannot but suggest that its cause originates on the surface, and not from the fundi of the glands, and that the irritant must exist in the vagina since it appears not to be effective within the canal.

"These considerations have led us to wonder whether, in many cases of cervicitis, there is not some factor other than bacterial infection responsible for the hypertrophy and activity of the gland layer, and, in view of the undoubted influence of ovarian hormones on other parts of the genital tract, it seems reasonable to suggest some disor-

* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

** From the Department of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis.

dered balance of these hormones, such as excessive production of oestrin.

"It is possible that the inflammation localized in the erosion, once it is present, may play a small part in establishing a vicious circle, but it does not seem extensive enough to account for such a profound anatomical and physiological upset as that which occurs in the glands in chronic cervicitis; may it not be that the glandular hypertrophy comes first, as a result of disordered hormone balance, and that this leads to spread of the columnar epithelium and gland layer on to the portio, where the intensely acid contents of the vagina cause loss of epithelial covering and superficial inflammation as a result of chemical, not bacterial, irritation of the exposed tissues."

The pathologic conditions which may be encountered are:

1. Laceration of cervix
2. Erosion
3. Eversion
4. Nabothian cysts
5. Ectropion
6. Polyps
7. Malignancy
8. Chancre
9. Leukoplakia
10. Condylomata
11. Stenosis

Diagnosis

The diagnosis of such cases usually starts with a physician who is doing general practice, but may later come to the attention of a gynecologist because of the chronicity of the symptoms in spite of various types of therapy. Therefore, a proper diagnosis is of the utmost importance in order to prescribe the best treatment for each individual case.

If the patient has been using some douches or other treatment before presenting herself for examination it may be necessary for her to return again after a day or two of no treatment in order to find the cause. The procedure then should be to obtain a specimen (before digital examination) on a sterile swab and wash it off into a Wassermann tube, containing 1 or 2 cc. of normal saline, which has been warmed to body temperature. Spin the swab in the saline to wash off the material. This tube may be kept warm in a shirt pocket until it can be examined or it may be placed in an incubator and examined several hours later. Allow it to settle and remove the supernatant fluid. Pour the sediment upon a clean slide and cover with a cover slip. Examine under low power with the light reduced. Another swab is used to obtain material for a smear which should be stained with Gram's stain (or methylene blue). A culture could be obtained at this time if desired but it is not essential.

The next step would be to test the reaction of the discharge in the vagina and cervix by means of the nitrazine paper, according to directions.

Lugol's solution should then be applied to show evidence of the presence or lack of sufficient estrogens (A deep mahogany stain indicates plenty of estrogens shading off to a light tan in their absence). This may also be applied as the Schiller test to locate areas of erosion, leukoplakia or cancer. By means of this procedure one may be led to the proper area for obtaining a biopsy. If a suspicious area is encountered a biopsy should be taken and in this way the general practitioner may obtain the diagnosis of a malignancy at the very early stage when it is amenable to treatment with the prospect of cure. If a suspicious area does not respond to minor therapy promptly, consider seriously the probability of cancer.

Patients who come in with the complaint of an irritable bladder but with few urinary findings are to be investigated with the idea possibly of finding the cause in a chronically inflamed cervix which is feeding a trigonitis via the lymphatics. Correction of the cervical disease then may be of primary importance in the relief of the bladder irritation.

Many such patients may come to you with rather indefinite symptoms of nervousness, backache, constipation, distention and belching. Arthritic symptoms may be predominant. In such cases chronic inflammation of the cervix may be acting as a focus of infection. Other foci should be investigated and the cervix should be properly treated.

Treatment

Treatment of the "cervicitis-vaginitis syndrome" may be medical, surgical, or combined medical and surgical. We should attempt to restore a normal physiologic state by obtaining the proper pH of the vagina, and if it does not remain normal after treat-

ment then removal of diseased tissue in the cervix is indicated.

Medical.—I rely primarily upon the use of lactic acid douches to restore the vaginal pH to normal.

		Cc.
Rx:	Acid lactic (85%), U. S. P.	60
	Aqua dist. q. s. ad.	240
Sig:	One teaspoonful in two quarts of water as a douche.	

This douche is a 1:2,000 solution of lactic acid and has a pH 3.2. It is nonirritating and when used one to three times daily as indicated in the particular case will maintain a vaginal pH 4.0 to 4.5. I recommend its use because it is a prescription, is uniform, is free from contamination (vinegar is not), and is economical. The above prescription is sufficient for sixty douches and retails for 85 cents or $1. Avoid the use of alkaline douches. Most commercial preparations are alkaline.

To supplement the effect of the douches, Floraquin tablets (Searle) may be used with good results. Two tablets are inserted well into the vagina after the evening douche for twelve days, and the conditions the checked again two days later after all treatment has been held in abeyance. In patients with Trichomonas infections most of the organisms have disappeared, but if one remains the previous conditions will probably recur as soon as treatment is relaxed. Lactic acid douches should be ordered three to five times daily during the menses. This is done without any harmful effect. Patients with Trichomonas infection should be examined again after the menses as this is the time the disease may recur. In case there are but a few trichomonads remaining, good results can usually be obtained promptly by the use of Devegan tablets (Winthrop) for twelve days. The arsenic present in these tablets usually kills the remaining organisms. This type of therapy resulted in a prompt cure in a patient who developed vaginitis due to amoebae subsequent to an attack of amoebic dysentery. The Devegan tablets should be moistened before being placed in the vagina as they do not disintegrate readily, but are effective in spite of this.

Roblee[5] prefers to use beta-lactose, 80 per cent, and boric acid, 20 per cent, in number eleven or twelve capsules. His results have been very satisfactory, but many patients object to this type of treatment and discontinue it too soon. Similar results may be obtained with lactic acid douches and patients will continue to follow the treatment.

Application of a solution of 10 per cent silver nitrate is helpful as a mild cauterizing agent in cases of erosion or small polyps. Its use should be discontinued shortly if satisfactory results are not obtained promptly or if there is any possibility of malignancy being present. In such cases obtain a biopsy.

In patients with marked edema of the cervix or pelvic induration the condition may be improved markedly by the use of a glycerin tampon for eighteen to twenty-four hours followed by lactic acid douches daily for a week or two. Further treatment can then be carried out with less danger of reaction.

The use of the Elliott treatment is of value when the application of heat is desired. Such procedures are time consuming and require space for treatment rooms which may not be available. It is not without hazards, as I have seen a patient whose vagina sloughed out following the rupture of the applicator during a treatment. I have used the Newman Thermo-Flo with some benefit and the danger of a burn is eliminated.

Copper ionization may be used with good results but is also time consuming and limited in scope.

Negatan (Lilly) offers a means of obtaining a styptic action on the cervix and allows it to heal.

In patients with yeast infections good results may be obtained by application of gentian violet, which is almost specific. Roblee recommends the use of beta lactose, 97 per cent, with resorcin powder, 3 per cent, in a number twelve capsule. Insert a capsule daily or less frequently according to the tolerance of the patient. The resorcin may cause considerable irritation. Aluminum acetate douches seem to be of some value in these infections but should be used only for a period of a couple of weeks, as longer usage may interfere with the restoration of the normal physiology of the vagina. Order

a teaspoonful in a quart of water as a douche once or twice daily.

In patients with no definite evidence of infection, look for the presence of an ovarian tumor and obtain the basal metabolic rate. Thyroid therapy may be indicated and when given may definitely diminish the amount of discharge. Such a condition is frequently encountered in patients in their teens.

Another endocrine picture is seen in patients near the menopause or later. Leukoplakia may be noted on the cervix or vagina and if there is evidence of estrogen deficiency, as told by the Lugol's test or vaginal smear, then therapy with estrogens may be of considerable value. However, one must be on the lookout for early malignant change.

Senile vaginitis may be avoided by the use of lactic acid douches after the menopause and may be relieved promptly by such therapy.

Antiseptics must be used with caution as they may eliminate the normal flora of the vagina (Doederlein bacilli) and interfere with the restoration of normal physiology in the vagina and cervix.

The use of the tampon type of protection during the menses should be strongly condemned as interfering with the normal physiology of the pelvis. Free drainage is interfered with, and the alkaline discharge is retained in the vagina longer than normally. Endocervicitis may result from their use and in a few cases even mild pelvic inflammatory disease occurs. Dysmenorrhea is frequently precipitated by such usage. Trichomonas vaginitis may start in nulliparous patients due to the trauma of application and the introduction of the organisms from the vulva into the vagina.

Surgical.—Surgical treatment of endocervicitis can be accomplished by means of the operation recommended by Sturmdorf. Occasionally hemorrhage may complicate such procedures but more frequently stenosis is the complication. Since 1934, treatment by conization has replaced the Sturmdorf operation on my service at St. Louis City Hospital, No. 1, and in my private work, with very satisfactory results.

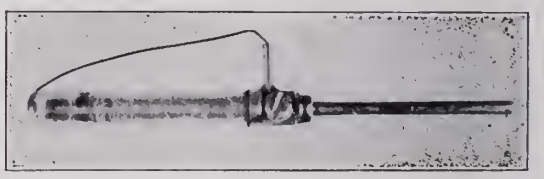
In patients with deep unilateral or bilateral laceration of the cervix trachelorrhaphy is frequently indicated in order to enclose the columnar epithelium within the cervical canal.

Cauterization of the cervix by the superficial striping method gives satisfactory results when the disease is superficial. Treatment of the cervix post partum is best done at from six to eight weeks and formerly was a rather routine procedure. Since we are attempting to restore the normal physiology of the vagina as soon as possible by the use of lactic acid douches (or similar means), the cervices heal so completely that the need of cauterization has been largely eliminated.

Coagulation of the diseased cervix was advocated by Roblee[6] for several years, but sloughs were slow in coming away and the resulting discharge obnoxious. Since 1937, he has modified his technic and is using conization. In a paper in 1938, the electrodes and the technic are clearly described.

Hyams[7] described a technic of conization of the cervix in which a very small amount of tissue was removed from the cervical canal. R. J. Crossen[8] modified the Hyams electrode so that it was in the shape of a number four and recommended its use for the removal of a cone-shaped portion of the cervix. This should be a hospital procedure. By extending the treatment, the cervix may be reduced almost to the extent of amputation. Conization can readily be used in the care of endocervicitis in the cervix remaining after supravaginal hysterectomy.

The Crossen electrode had a porcelain stem which was readily broken by the novice and could not be repaired. I[8] modified the construction of the electrode so that it has a nonbreakable metal core covered by lucite as an insulator.* Should the wire be broken it could be replaced by threading a new nichrome wire of desired size through the electrode and tightening a set screw which fixes



* This electrode can be obtained from Washington University Medical School, Department of Mechanics, 4580 Scott Avenue, St. Louis, Missouri.

(Continued on page 168)

Syphilis in Wisconsin

By W. F. LORENZ, M. D.*
Madison

THERE are now two sources of information on the incidence of syphilis in Wisconsin. The required blood test on applicants for marriage and the routine blood test on selectees together now supply data on over one quarter of a million young adults. The average age in both of these groups is approximately the same. The vast majority fall between the ages of 20 and 30. The incidence of syphilis in the combined group is between 6 and 7 per 1,000.

Premarital Blood Tests

Compulsory blood tests for syphilis on applicants for a marriage license became effective in Wisconsin on July 1, 1937. From that time up to December 31, 1941, blood specimens from 164,732 persons have been received at our laboratory labelled "marriage license," or some similar designation. Of these 164,732 persons, 1,063 were found to have positive blood tests for syphilis. This represents a rate of 6.5 per 1,000. The vast majority of these syphilitic persons was wholly unaware of such an infection. Very likely few, if any, had any readily detectable clinical manifestations of syphilis. It is evident that the discovery of syphilis was a surprise. In every instance the blood tests were repeated and only upon such confirmation was the diagnosis made final. In short, the possibility of error was fully covered and the final result as to the incidence of syphilis is as accurate as blood test information will permit.

In this particular group of predominantly young adults with a syphilitic infection one finds a remarkable fact. The incidence of syphilis is practically the same in the sexes; 49 per cent of these cases are females and 51 per cent are males.

The fact that the vast majority of these young adults with syphilis was ignorant as to any such infection is another significant circumstance. It seems highly probable that syphilis was not even suspected, otherwise plans for marriage, in Wisconsin at least, would not have been made without first seeking definite information. It is certainly an embarrassing circumstance to have a license to marry refused by the county clerk; the implication is obvious. The knowledge that blood tests are required is now very general. As a consequence, any young person with knowledge or doubt as to any previous venereal disease is likely to have a preliminary test made, that is, before applying for a license. Such cases might not then appear in the group we are reporting. Furthermore, on that basis the number of syphilitic persons found in this premarital class is practically a minimum for this general age group. The rate found then becomes the incidence of unknown and unsuspected syphilis in the young adults of our general population.

Selective Service Examinations

From the latter part of 1940 up to December 31, 1941 we received blood specimens from 84,701 selectees. Of these, 502 were found to be positive for syphilis. This represents a rate of slightly less than 6 per 1,000. Vonderlehr and Usilton[1] reported a rate of 6.3 per 1,000 for Wisconsin based upon 24,066 cases.

It is interesting to note that the incidence of syphilis in our general population is adversely influenced through the relatively increased frequency of syphilis in the colored races. This influence is serious in many southern states and in larger cities. Even in Wisconsin it is noticeable, although the colored element in our population is small. For example, among the 502 syphilitic persons found among the selectees, 67 are negro, 15 Indian and 4 Asiatics. Eighty-six or 17 per cent of the 502 cases of syphilis is a rate out of proportion to the number of negro, Indian and Asiatic in our general population. Vonderlehr and Usilton[1] found the rate in

* From the Wisconsin Psychiatric Institute, University of Wisconsin.

the negro to be thirteen times more than that found in the white race.

Perhaps some slight corrections in generalizing from blood test information should be considered. Blood tests are not 100 per cent positive in all the various phases of syphilis. For example, during the chancre stage, all tests, including the most sensitive, may be negative during the first five or ten days,—sometimes much longer. During and following a course of intensive treatment all tests may be negative. During clinical latency the less sensitive tests may be negative. Prompt and effective early treatment may result in a prolonged phase of negative blood tests. Late in the course of neurosyphilis the blood may be negative. This is seen not infrequently in tabes dorsalis.

In short, syphilis in some of its many phases may not be associated with a positive blood reaction. However, these and other limitations in the blood test for syphilis are necessary considerations in the clinical application of this laboratory information. They are really insignificant in estimating the rate of syphilis in a population. Furthermore, from the standpoint of public health it must be held in mind that 99 per cent of untreated syphilis in a communicable stage is associated with a positive blood reaction. The only exception to this is the brief negative phase early in the initial stage.

From a statistical standpoint the other source of error is the occasional case of positively reacting blood unassociated with syphilis. Leprosy and malaria are well known instances of such so-called "false positive." Both are practically non-existent in Wisconsin. It is also well known that occasionally positively reacting blood is found in a variety of other disease conditions. This possible error is negligible because the group under consideration is composed of healthy normal young adults ready to be married or enter military service. Finally there is the occasional case of positively reacting blood in a perfectly normal, nonluetic person. The estimated[2] rate of such is about 1 per 5,000 persons. Allowances can be made for these various possibilities without reflecting any significant change in the rate of syphilis compiled from these data.

There still remains for brief consideration the nature of the blood tests used in these two groups, particularly if findings in Wisconsin are to be compared with the findings in other states. Routinely we use one exceedingly sensitive flocculation test developed at the Wisconsin Psychiatric Institute which was reported to be over 90 per cent sensitive in the evaluation studies carried on by the U. S. Public Health Service.

All patients reacting to any degree on this preliminary supersensitive test are retested by more conservative and more specific procedures. The confirmatory tests we employ are the "Kline," the "Kolmer quantitative," the "Kahn" and the "Eagle micro-flocculation." Our results with these procedures have been rated in the U. S. Public Health studies recently reported by Parran, et al.[3] Our performance of the "Kline diagnostic," the "Kolmer quantitative" and the "Eagle micro-flocculation" received high ratings both in sensitivity and specificity. The last was reported on in 1940; the former two in 1941. The final serologic result we report is the combined information obtained from this battery of tests applied to a single specimen of blood. Any comparison of our results with that reported from other states must take into consideration the relatively high degree of sensitivity that we employ. Because of this, our findings tend to be the maximum for syphilis so far as any present day laboratory procedure can be used for that purpose.

It is noteworthy that the incidence of syphilis in Wisconsin is very low. According to Vonderlehr and Usilton's[1] recent report on the incidence of syphilis among selectees the lowest rate was found in New Hampshire (5.8 per 1,000). Wisconsin was reported as showing the next lowest, that is, 6.3 per 1,000. The next lowest were Massachusetts and North Dakota with 7.1. The findings in the City of Milwaukee are equally significant in this respect. In their report on cities of from 500,000 to 1,000,000 population, Milwaukee showed a rate of 11.6 per

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Comments on Treatment

Editor—A. J. QUICK, M. D., Marquette University, Milwaukee

Chloral Hydrate

Sedatives and hypnotics have always occupied an important position in therapy. No sharp differentiation can be made between a sedative and a hypnotic drug. By definition the former reduces the sensitivity of the central nervous system while the latter induces sleep. In practice, the same drug acts both as a sedative and as a hypnotic. To obtain the first effect the drug is administered in smaller doses and during the day, while the soporific action is usually secured by increasing the dosage and giving it at bedtime.

Chloral hydrate, although not used extensively during recent years is one of the best known hypnotic drugs. It was introduced into therapy over seventy years ago, and during this long period most of its virtues and faults have been uncovered. In its favor are its cheapness, relative safety, and effectiveness. Against it are its disagreeable taste and odor, its irritating action, its toxicity under special conditions, and its lack of analgesic power.

The recommended dose of chloral hydrate varies from 5 to 30 grains. All too frequently a far greater amount is given than is necessary to obtain the desired hypnotic effect. A safe rule to follow in regard to all soporific drugs is to begin with the minimum effective dose and increase gradually. The physician often overlooks the fact that in many cases all that is needed is a certain amount of sedation and that the faith of the patient in the drug will accomplish the rest. Often 5 grains of chloral hydrate will produce satisfactory sleep. Since the drug is readily soluble in water, it can be prescribed in solution as follows:

Chloral hydrate	ʒ iiss (10 Gm.)
Fluid extract glycyrrhiza	℥ lj (60 cc.)
Syrup of orange to make	℥ iv (120 cc.)

Label: One teaspoonful well diluted with water one hour before bedtime.

Since one teaspoonful contains only 5 grains, the dose may readily be increased to two teaspoonfuls or more if needed. It should be mentioned that chloral hydrate must not be dispensed in an alcoholic vehicle.

The dose of chloral hydrate as a sedative is from 2 to 3 grains three times a day. It is often given with sodium bromide in a prescription such as the following:

Chloral hydrate	gr. xxx (3 Gm.)
Sodium bromide	ʒ iss (6 Gm.)
Syrup of orange	℥ iv (120 cc.)

Label: One teaspoonful diluted with water three times a day.

It is well to remember that sodium bromide is eliminated slowly and consequently will accumulate. Therefore the same complications as those of bromide medication alone may arise.

The action of chloral is prompt and is especially effective in insomnia due to nervous excitement. In therapeutic doses there is no evidence that it injures either the heart or the liver, but its use in severe liver damage is contraindicated since its action is apt to be unduly prolonged and pronounced when the detoxifying power of the liver is impaired. Because of its disagreeable taste it is less likely to be habit forming than most of the other hypnotic drugs. When the cost of medication becomes a factor, chloral hydrate deserves especial attention since it is cheap and can be dispensed in solution.

Chloral hydrate is of little value in insomnia due to pain since it has no analgesic action. The drug should not be given to patients with gastritis, ulcers or other gastric disease since it has a marked irritating action.

In spite of the many excellent hypnotics that are now available, chloral hydrate still deserves a place in therapy. Because of its taste and odor it will not suit the fastidious patients, but it still remains an effective drug that has little after effect and seldom causes untoward side reactions. A. J. Q.

Introducing

Walter V. Price, Ph. D., and Catherine J. Personius, Ph. D.

THAT Wisconsin is America's Dairyland would, in itself, be no justification for emphasizing the value of dairy products in this series on nutrition, the first line of home defense. But ample justification is found in the enormous food value which dairy products supply, and in the fact that Wisconsin leads America in the science and practice of dairying.

The two authors of this month's article, "Wisconsin Cheese," are Mr. Walter V. Price, an expert in the fields of cheese manufacture and cheese analysis, and Miss Catherine J. Personious, a careful and capable worker in foods, and at present conducting research on cheese.

Mr. Price took his undergraduate and graduate work in dairy industry at Cornell University. Then, as a member of the faculty, he worked with one of America's greatest dairy scientists, Lucius L. Van Slyke, in the authorship of "Cheese," the standard textbook in that field of dairying.

Mr. Price entered Cornell in 1914, took a couple of years off for service in the United States Navy during World War I, and received his B. S. degree in 1920. He earned his Ph. D. degree in 1925. During leaves of absence from Cornell he also gained valuable experience in the employ, first as a workman and later as manager, of a dairy condensery, market milk plant, and ice cream factory.

By 1927, Mr. Price earned the rank of full professor at Cornell. In 1928, he came to Wisconsin as full professor in the dairy industry department. Since then he has directed research and done a great deal of experimental work himself, along with teaching and the writing of a number of technical papers on dairy manufacture.

Miss Personius, too, has a rich background in research work along the lines of foods, at present being in charge of food technology research at the University of Wisconsin. She is directing, among other experiments, the examination of the cooking qualities of various types of cheese.

Miss Personius took her undergraduate work at Elmira College in New York State, and on her graduation in 1925 she continued for two years on the faculty of the college. Then, after a year of graduate work in home economics education at Columbia, Miss Personius went to Hampton Institute to teach courses in foods.

She went to Cornell as a faculty member in 1930, and then did part-time study, earning her Ph. D. degree in 1937. During the summer session of 1936 she taught a course in experimental foods at the University of Minnesota, but on completion of her doctorate requirements in biological and physical chemistry and bacteriology at Cornell she stayed with that university as assistant professor of foods. Then in 1940 she came to Wisconsin to teach and to conduct research.

Her present research work is notable as an example of applying the principles of physical and colloidal chemistry to a study of foods.

—STEPHEN E. GAVIN, M. D., Fond du Lac.

IN THIS BUILDING in 1890 Wisconsin set a pattern for the rest of the nation, demonstrating how the abstract findings of science could be applied to dairying for the benefit of the whole industry. Here practical dairymen met half a century ago in the University of Wisconsin's dairy school, the first ever held in America.

The history of this state's dairying begins more than 100 years ago when Vermont Yankees, stocky Germans, thrifty Scandinavians, and democratic Swiss brought their herds across the continent, cleared their Wisconsin woodland acres, and took up the business of farming.

The second page in that history was written when the University of Wisconsin, recognizing the part that science must play in progress, undertook the scientific analysis of the dairy industry and its techniques. That page is brightened by such discoveries as the universally accepted Babcock test for butterfat, the Babcock–Russell cold-cure process for cheese, which is the foundation of the modern cheese industry; the application by H. L. Russell of the bovine tuberculin test; and the extensive research work of such others as Farrington, Hart, Steenbock, Elvehjem, Weckel, Hastings, Sommers, and Price.

But the brightest page of all was when these men realized that, whatever practical virtues a certain scientific discovery may appear to have in theory and in the technical journals, such a discovery is of no immediate practical value until it can be extended to actual existing problems. Science itself is not an end, but a means to an end.

So, to apply these scientific studies which the University laboratories were making, the college convened its first annual dairy school in the winter of 1890 to teach to practical farmers and dairy manufacturers the practical aspects of laboratory work.

Enrollment in the dairy school has grown. That, in itself, is no mean tribute to the men who, by their foresight, extended their research findings right to the dairy farm. No less a tribute is the fact that other colleges and universities all over America have accepted the dairy school idea.

But the greatest tribute of all is the fact that this state, its college, and its dairymen are universally accepted as the American pioneers of applied dairy science.

Wisconsin Cheese

By WALTER V. PRICE, and CATHERINE J. PERSONIUS*

CHEESE is one of the most important single foods in this period of international emergency. Not only is it a good nutrient for American consumers, but now that shipping losses and the course of the war have limited the tonnage of food that can be sent abroad, Wisconsin's number one dairy export has become Britain's number one food import.

Great Britain can bring in only such foods as carry greatly concentrated protein, energy, and vitamins, because every pound of food shipped across treacherous waters must be loaded with health and nourishment. And the requests and orders from abroad re-emphasize the importance of cheese as the one food which, more than any other, will fill the bill.

That view should confirm for Wisconsin men and women the importance of the dairy state and its food products in world affairs. But more than that, it should force Wisconsin people to re-examine the nutritive values of those products. When people several thousand miles away put cheese first on their national diet, it's about time America's dairyland found out why.

Cheese is a Condensed Food

Most people have read, from time to time, fanciful predictions that soon man will get all his food in capsule form. Most thinking people are sure that the goal is a long way off, and science is quite positive that the aim is not to be desired. But science has no such doubt about cheese. For despite the fact that it approaches very closely to the aim of concentration of food values, it has the approval of medicine, biochemistry, and nutrition. All three fields agree that it is a valuable concentrated food supply.

What's more, the men of the scientific laboratories are not alone in their recognition of the worth of cheese. All over America; all over the world, in fact, its popularity as a table delicacy is unquestioned.

Cheese is the internationalist of foods. It is not limited to a single state, nation, or even continent.

Down the list of varieties are such picturesque types as Monk's Head, produced by the holy men of Bern, Switzerland; Abertam, a Bohemian sheep's milk cheese; Banbury, from England; Alpin, from the heights of the French Alps; Chhana cheese from Asia; Dutch Commission cheese; Portuguese Alemtejo; Italian Chiavari; Hungary's Damen; Scotch Dunlop; Finnish Egg cheese, produced from fresh milk and eggs; Danish Gislev; Austrian Gray; Ilha from the Azores Islands; Silesian Josephine; Lapland cheese; Buttermilk cheese; Mesitra from the Crimea; Swedish Mysost; California Jack cheese and Wisconsin Brick; Pineapple, so-called from its shape; Porto Rican Queso du Puna; Swedish Reindeer Milk cheese; Argentine Tafi; Mexican Tuna; Tworog from Russia; Swiss Ziger; and Trappist cheese, originated in Bosnia in the Trappist monasteries.

Cheese Varies in Many Ways

These are all variations of some of the original cheese types, and yet each of them differs slightly in shape, size, and curing qualities. Timing, weight, test of milk used, type of milk employed, and length of curing, are all factors in the quality of cheese produced. Even the size of a cheese may vary its quality.

All these are easily variable items, and they have a profound effect on the way the final product tastes. But one thing does not change in the whole process; a good job of cheese manufacture will produce a cheese that possesses much of the nutrients that the milk contained, all securely sealed in the final product.

Proteins and Energy? Eat Cheese

Cheese is not a by-product. It is, on the other hand, a concentration of almost all the food values which make milk itself a "must"

* As told in an interview with Bryant Kearl.

on any menu. Most of those values carry through to cheese, which, though it is greatly changed from milk in composition and consistency, in the final analysis supplies much of the heat and energy, substantially all the growth-promoting proteins, and apparently all the essential vitamins which characterize milk itself. The cheese has lost most of the sugar, ash, and albumen which were contained in the milk, but the fat and other protein nutrients are almost completely retained.

To see just what happens to the original milk and its food components, let's follow through the cheesemaker's process.

He starts with whole milk—milk that tests, let us say, 3.5 per cent butterfat. That means that 100 pounds of milk will contain 3.5 pounds of pure fat, the most efficient of the food stuffs as a source of energy; as well as about 87 pounds of water; 2.5 pounds of casein, the complete dairy protein; 0.5 pound of added protein in the form of albumen; and about 6 pounds of sugar and ash.

In his process the cheesemaker first eliminates much of the water, and with it he loses most of the sugar, ash and albumen. But he retains about 3.2 pounds of fat (a negligible loss of about 5 ounces); 2.3 pounds of casein, the dairy protein (a loss of only 3 ounces of that nutrient, too, in the whole manufacturing process); and a little over 0.5 pound of sugar and ash.

Minerals and Vitamins? Eat Cheese

Although much of the ash is lost, the nutritionally important minerals, calcium and phosphorus, are carried through in quantity from milk to cheese. An ounce of good cheddar, yielding a little over 100 heat calories and more than 6 Gm. of protein, has at least ¼ Gm. of calcium, and ⅕ Gm. of phosphorus. Two and a half ounces of cheese daily amply fill an adult's calcium needs, and go a long way toward supplying phosphorus requirements.

Nutritionists recognize that it requires a very carefully selected diet to supply an adult's calcium needs unless cheese or milk constitute a part of that diet.

SCIENCE PROVES THERE'S HEALTH IN CHEESE

Cheese helps build stronger muscles—Protein abundantly provided.

Cheese helps build firmer bones—Contains calcium and phosphorus.

Cheese furnishes heat and energy—Whole milk cheese is a rich source of fat.

Cheese helps keep us well—Contributes vitamins for health and growth.

Cheese is a health food.

As for vitamins, the best surveys conducted to date show that vitamins A and D carry through almost unharmed in the process of converting whole milk to cheese. Virtanen and Kreula, Finnish scholars, report that vitamin A and carotene, from which vitamin A may be synthesized in the body, are both preserved, at least in Swiss cheese, during the manufacturing and ripening process. Balsamelli carried on more extensive studies with cheese samples of various types and ages to show that fresh, ripened, and pasteurized whole milk cheeses of all kinds may be a rich source of vitamin A and fairly rich in vitamin B_1 (thiamin). The League of Nations' Committee on Nutrition lists cheddar cheese as a good source of riboflavin as well, and that same committee puts cheese on the recommended diet for pregnant or nursing women as a source of proteins, fats, calcium, and vitamins.

Most milk used in cheesemaking contains only small amounts of vitamin D, and so cheese is not an exceptionally rich source of this vitamin.

At one time there was even some suggestion that cheese might be proportionately richer than milk in certain vitamins, either by its transformation of those vitamins in the curing process or by its creating a food product from which the body could synthe-

size added vitamin A. Both Davies and Moore of Cambridge disproved any theory of added vitamin value in cheese some years ago. They noted, however, that people might easily believe that theory, because whole milk cheese is such a concentrated food that its share of vitamins by weight is much greater even than that of the milk from which it comes.

Some Types of Cheese Use Skim Milk

It would be a mistake to assume that all cheese is produced from rich whole milk. Some varieties by their very nature require the use of skim milk, and some of the whole milk varieties of ripened cheese may be produced using skim milk. But this latter class of cheese gives itself away to a discriminating buyer, for it is usually rough, hard, rubbery, and lacks palatability.

Of the types of cheeses which are always made from separated milk, cottage cheese heads the list. It is generally produced from skim milk which has been soured by special cultures. But then fat is added to the curds, so that the completed process finds a pail of cottage cheese made up of about three-fourths water, a little less than one-fourth protein, about 4 per cent fat, and some of the minerals which were present in the milk. It should be noted that since cottage cheese is an acid-curd cheese, in its manufacture most of the calcium is discarded with the whey.

Other types of cheeses are also essentially produced from skim milk, with Neufchatel being the chief example. But in this variety, too, cream or whole milk are frequently added sometime during the process, so that it contains anywhere from 12 to 25 per cent fat in the final form.

Skim Milk Cheeses For the "Reducing" Diet

The skim milk cheeses, even with some small quantity of fat added, are healthful, easily digestible, and not especially fattening. Frequently people who are unable to handle much fat in their diet request unfortified cottage cheese or Neufchatel, and in that form, they get nutritionally complete proteins, but few calories. The skim milk cheeses do not contain vitamin A except when cream has been added to them during manufacture; in that case they are good auxiliary sources of the vitamin.

All the cheeses named so far (cottage cheese, Neufchatel, and enriched Neufchatel) are classified technically as "soft" cheeses. The class has several other representatives, too. Limburger and cream cheese are both soft cheeses, and both of them contain much of the original nutrients which make up the milk from which they are manufactured.

Cheese Comes in Three Classes

There are three general classes of cheese: "soft," "semi-hard," and "hard." In the division of semi-hard cheeses, Roquefort and brick are the best known in this country. One type of Roquefort which is made from a brittle, friable curd obtained from uncooked cow's milk further ripened by molds, was imported to this country at first under the name of "bleu cheese," the French name, and so is usually known as blue cheese in the United States.

Roquefort proper and blue cheese are produced by a similar process except that Roquefort itself is made up in part from sheep's milk.

Brick, which first achieved great popularity in Wisconsin, is a semi-hard cheese made from whole milk cooked and then ripened by bacterial action.

The main examples of the hard cheeses are Edam and Gouda, Cheddar, Swiss and Parmesan. Edam and Gouda are less important in this country than some of the other cheeses, but in some parts of Europe they are the staple cheese. Both are peculiar in that they ripen without forming the gas holes which appear in Swiss and a few other ripened cheeses of the "hard" class.

Cheddar is America's Staple Cheese

Cheddar is divided into several subclasses: English Cheddar, American, Danish, and others. It is the standard hard cheese in America, made from cooked whole milk which is compressed and ripened with bacterial action.

(Continued on page 170)

The Nation at War

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Recommendations to All Physicians With Reference to the National Emergency

Editor, Journal American Medical Association
Editors, State Medical Journals
Secretaries, State Medical Associations

Inasmuch as this material represents one of the most important responsibilities of the medical profession at the present time, it is the opinion of the Assignment and Procurement Service that it deserves the most prominent place in your JOURNAL it can be given. It is of equal importance to doctors themselves since it clarifies quite largely the demands which will be made upon the medical profession.

Sincerely yours,
FRANK H. LAHEY, M. D., *Chairman*
HARVEY B. STONE, M. D.
JAMES E. PAULLIN, M. D.
HAROLD S. DIEHL, M. D.
C. WILLARD CAMALIER, D. D. S.

SAM F. SEELEY, M. D.,
Executive Officer
Procurement and Assignment Service

I. Medical Students

A. All students holding letters of acceptance from the Dean for admission to medical colleges and freshmen and sophomores of good academic standing in medical colleges should present letters or have letters presented for them by their deans to their local boards of the Selective Service System. This step is necessary in order to be considered for deferment in Class II-A as a medical student. If local boards classify such students in Class I-A, they should immediately notify their deans and if necessary exercise their rights of appeal to the Board of Appeals. If, after exhausting such rights of appeal, further consideration is necessary, request for further appeal may be made to the State Director and if necessary to the National Director of the Selective Service System. These officers have the power to take appeals to the President.

B. Those junior and senior students who are disqualified physically for commissions are to be recommended for deferment to local boards by their deans. These students should enroll with the Procurement and Assignment Service for other assignment.

C. All junior and senior students in good standing in medical schools, who have not done so, should apply immediately for commission in the Army or the Navy. This commission is in the grade of Second Lieutenant, Medical Administrative Corps of the Army of the United States, or Ensign H.V. (P) of the United States Navy Reserve, the choice as to Army or Navy being entirely voluntary. Applications for commission in the Army should be made to the Corps Area Surgeon of the Corps Area in which the applicant resides and applications for commission in the Navy should be made to the Commandant of the Naval District in which the applicant resides. Medical R.O.T.C. students should continue as before with a view of obtaining commissions as First Lieutenants, Medical Corps, upon graduation. Students who hold commissions, while the commissions are in force, come under the jurisdiction of the Army and Navy authorities and are not subject to induction under the Selective Service Act. The Army and Navy authorities will defer calling these officers to active duty until they have completed their medical education and at least 12 months of internship.

II. Recent Graduates

Upon successful completion of the medical college course, every individual holding commission as a Second Lieutenant, Medical Administrative Corps, Army of the United

States, should make immediate application to the Adjutant General, United States Army, Washington, D. C., for appointment as First Lieutenant, Medical Corps, Army of the United States. Every individual holding commission as Ensign H.V. (P), U. S. Navy Reserve, should make immediate application to the Commandant of his Naval District for commission as Lieutenant (J.G.) Medical Corps Reserve, U. S. Navy. If appointment is desired in the grade of Lieutenant, (J.G.) in the regular Medical Corps of the U. S. Navy, application should be made to the Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

Graduates who have failed to obtain a Medical Administrative Corps or Ensign Commission run the risk of being inducted into the military service as enlisted men under the provisions of the Selective Service Acts.

III. Twelve Months Internes

All internes should apply for a commission as First Lieutenant, Medical Corps, Army of the United States, or as Lieutenant (J.G.), United States Navy or Navy Reserve. Upon completion of 12 months interneship, except in rare instances where the necessity of continuation as a member of the staff or as a resident can be defended by the institution, all who are physically fit may be required to enter military service. Those commissioned may then expect to enter military service in their professional capacity; as medical officers; those who failed to apply for commission are liable for military service under the Selective Service Acts.

IV. Hospital Staff Members

Internes with more than 12 months of interneship, assistant residents, fellows, residents, junior staff members, and staff members under the age of 45, fall within the provisions of the Selective Service Acts which provide that all men between the ages of 20 and 45 are liable for military service. All such men holding Army commissions are subject to call at any time and only *temporary deferment* is possible, upon approval of the application made by the institution to the Adjutant General of the United States Army certifying that the individual is temporarily indispensable. All such men holding Naval Reserve commissions are subject to call at any time at the discretion of the Secretary of the Navy. Temporary deferments may be granted only upon approval of applications made to the Surgeon General of the Navy.

All men in this category who do not hold commissions should enroll with the Procurement and Assignment Service. The Procurement and Assignment Service under the Executive Order of the President is charged with the proper distribution of medical personnel for military, governmental, industrial, and civil agencies of the entire country. All those so enrolled whose services have not been established as essential in their present capacities will be certified as available to the Army, Navy, governmental, industrial, or civil agencies requiring their services for the duration of the war.

V. All Physicians Under Forty-Five

All male physicians in this category are liable for military service and those who do not hold commissions are subject to induction under the Selective Service Acts. In order that their service may be utilized in a professional capacity as medical officers, they should be made available for service when needed. Wherever possible, their present positions in civil life should be filled or provisions made for filling their positions, by those who are (a) over 45, (b) physicians under 45 who are physically disqualified for military service, (c) women physicians, and (d) instructors and those engaged in research who do not possess an M. D. degree whose utilization would make available a physician for military service.

Every physician in this age group will be asked to enroll at an early date with the Procurement and Assignment Service. He will be certified for a position commensurate with his professional training and experience as requisitions are placed with the Procurement and Assignment Service by military, governmental, industrial or civil agencies requiring the assistance of those who must be dislocated for the duration of the national emergency.

VI. All Physicians Over Forty-Five

All physicians over 45 will be asked to enroll with the Procurement and Assignment Service at an early date. Those who are essential in their present capacities will be retained and those who are available for assignment to military, governmental, industrial or civil agencies may be asked by the Procurement and Assignment Service to serve those Agencies.

The maximal age for original appointment in the Army of the United States is 55. The maximal age for original appointment in the Naval Reserve is 50 years of age.

All inquiries concerning The Procurement and Assignment Service should be sent to The Executive Officer, 5654 Social Security Building, 4th and Independence Avenues, SW, Washington, D. C., and not to individual members of the Directing Board or of committees thereof.

Total Entrance Pay and Allowances in Government Services*

	Without Dependents	With Dependents
Colonel—Army Captain—Navy Medical Director, U. S. P. H. S.	$5176	$5872
Lt. Col.—Army Commander—Navy Sr. Surgeon, U. S. P. H. S.	$4676	$5588
Major—Army Lt. Commander—Navy Surgeon, U. S. P. H. S.	$3936	$4848
Captain—Army Lt. Sr. Gr.—Navy Passed Asst. Surg. U. S. P. H. S.	$3336	$3792
1st Lt.—Army Lt. Jr. Gr.—Navy Asst. Surg., U. S. P. H. S.	$2696	$3152

The annual base pay is increased at the rate of 5 per cent thereof for each three years of service up to thirty years. Full time will be computed for all periods during which men have held commissions as officers in the Army, Navy, Marine Corps, Coast Guard, Coast and Geodetic Survey and Public Health Service, or in the National Guard or Naval Militia, the National Naval Volunteers or the Naval Reserve Force or Marine Corps Reserve, when confirmed in grade and qualified for all general service, and with full time for all periods during which they have performed active duty under Reserve commissions, and with one-half time for all other periods during which they have held Reserve commissions.

Uniforms and equipment of medical officers entering the army cost approximately $200. Officers entering the navy for the first time receive an allowance of $250 for uniforms and equipment.

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* Reprinted from the *Bulletin of the Medical Society of County of Kings and Academy of Medicine of Brooklyn*, New York, January, 1942.

The Doctor's Contribution*

The contribution of the medical profession to national defense deserves the widest possible recognition and understanding.

Since the passage of the Selective Service Act, some 6,444 medical boards have been established in this country. They have claimed the services of more than 25,000 physicians and 6,000 dentists. These men have examined upwards of 2,000,000 selectees—and they have not received one solitary penny in remuneration. And that contribution has been made at a time when most groups are looking for new ways to tap the Federal Treasury.

This nation's goal is not to merely create and train a big army. The goal is an army which will be physically and mentally superior. The doctors who have given their services so freely to the nation are doing much to bring that about. The examinations provided selectees are complete and searching. In thousands of instances they have been the means of unearthing disabilities that men did not know they had, and starting them on curative programs. And after a selectee is taken into the army, he is given further exhaustive examinations and tests by the Army Medical Corps, which is largely made up of reserve medical officers who have been called into service from private life.

It can be said categorically that this is the healthiest army we have ever had. The physical requirements are unprecedently high—far higher, for instance, than those prevailing in Europe. The doctor plays a great role in national defense.

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* Reprinted from *Watertown Times*, December 31, 1941.

One Hundred First Anniversary Meeting

September 14, 15 and 16

In the scientific program and the exhibit section special emphasis will be placed on the physician in war.

Report of Committee on Medical Defense to Council, January 10

By R. E. FITZGERALD, M. D.
Chairman, Milwaukee

WE ARE at war and our President has said, "We shall need 6,000,000 men in our army to end the war." Prime Minister Churchill in an interview said, "We shall overpower our adversaries on their own soil." If what these gentlemen say is correct, we shall require some 42,000 doctors to take care of our fighting forces,—about 7,000 doctors for every million soldiers. At the present time there are some 180,000 licensed physicians in the United States; 18,000 of these are incapacitated. There are 58,767 physicians over 55 years of age; at least one-half of the remaining doctors are not physically able to meet the army or navy requirements, and about two-thirds of the remainder would be engaged in appointments so necessary to civilian life that they could not be spared for military duty.

Each year about 3,500 doctors die and about 5,000 new physicians are graduated from the seventy-six Class A schools. A little better than one-half of these graduates are able to pass the physical requirements of the armed forces. Civil service commissions provide physicians for many agencies, such as the Indian, Bureau of Mines, Coast Guard Service, and Department of Pensions. Many other groups employ some 2,500 doctors a year and employ about 400 new men each year for replacements or new positions. The U. S. Veterans' Bureau employs 1,800 full-time physicians. The U. S. Public Health Service needs 35 doctors a year for replacements; this department also maintains a reserve officers' unit.

At the present time the U. S. Army needs about 1,500 more physicians; to date the Navy is fully equipped but will need about 700 physicians on July 1, 1942. We have a number of sponsored groups organized which will take a great many of the physicians in the specialty groups. For instance, there are sixty-eight general hospitals, thirty evacuation hospitals, and thirty-five surgical hospitals. The reserve officers of these units may be called and attached to other organizations, but when their units are called they may be detached from the service to which they have been assigned and returned to the sponsored group. This, in short, gives you a resumé of needs as far as the medical profession is concerned; it is self-evident that the need for physicians during this emergency will be tremendous.

How are we going to meet this situation? On October 30, 1941, President Roosevelt signed the Procurement and Assignment Bill which directs the American Medical Association to supply the need. Under the provisions of that bill, nine corps areas have been established, and one physician has been appointed chairman for each corps area. We are located in the Sixth Corps Area which consists of Wisconsin, Michigan and Illinois. Dr. Charles H. Phifer, of Chicago, is the corps area chairman, with Dr. J. Milton Robb, Detroit, and the chairman of our Council, Dr. Stephen E. Gavin, Fond du Lac, serving as committee members.

Each corps area committee will consist of a chairman, one physician representing medical education, one representing hospital associations, two physicians selected at large, two dentists, and one representative of the veterinary profession. In like manner, each state will be organized and will be represented by physicians, dentists, and veterinarians. Each county will have local committees which will provide accurate information regarding the status of each physician concerned.

Whenever any department of the government puts in a requisition for a physician or physicians, the Procurement and Assignment Service organization will investigate the necessary requirements and from the card index will be able to ascertain in a short time

the doctors who are qualified to fit the need of the moment. Under the Procurement and Assignment Service arrangement, all-out aid must be given to the government in all of its manifold medical requirements, and each physician must be prepared to serve his country in whatever capacity he is called upon, be it in the army, navy, marines, public health, U. S. Veterans' Bureau, industry, or in safeguarding the health of the civilian population.

Your committee has been deeply engrossed in the matter of Civilian Defense, and for that reason it has been found necessary to appoint an M-day chairman in each county, in order that we might cooperate quickly and fully by disseminating the material and information that has been distributed in such profusion by the National Council of Civilian Defense. We have contacted the executive secretary of the Wisconsin Council of Defense, Mr. Willoughby, and he has been exceedingly helpful to us, as has Dr. C. N. Neupert, chairman of the Health and Welfare Section.

It is the opinion of the committee that each councilor should impress upon the society or societies which he represents, the necessity for assembling complete, accurate and detailed information concerning each physician for the use of the Council of Civilian Defense and the Procurement and Assignment Service. We cannot stress too strongly the importance of this plan as a statewide project, for on its completion depends the success or failure of supplying our armed forces and civilian population with the right physician in the right place.

TO PREMEDICAL AND MEDICAL STUDENTS

OPPORTUNITY FOR APPOINTMENTS AS ENSIGNS IN CLASS H-V(P) UNITED STATES NAVAL RESERVE

The secretary of the Navy recently approved a change in Navy regulations whereby it is now possible for those premedical students who have been accepted for entrance to, and all medical students in, Class "A" medical colleges, to be appointed in the United States Naval Reserve in Class H–V(P), provided they meet the physical and other requirements for such appointment.

Students who are acceptable will be given provisional commissions as Ensigns, and it is the policy of the Bureau of Medicine and Surgery not to nominate such officers for active duty until after they have completed their prescribed medical studies and shall have served one year's satisfactory internship in a civilian hospital accredited for interne training, or shall have been accepted as Acting Assistant Surgeon in the Navy for interne training.

Upon graduation, and when the bureau has been informed of this fact by the Dean, commissions as Lieutenant (junior grade) MC–V(G), USNR, will be issued to provisional Ensigns and, after serving their internship in non-naval hospitals, they will be nominated for active duty. Application for, or acceptance of, either a provisional or permanent commission in the Naval Reserve, does not preclude the possibility of applying for a commission in the Medical Corps of the regular Navy. Persons affiliated with the Naval Reserve are not subject to induction into Army service by action of local Selective Service Boards.

Navy regulations require that all applications for appointments in the Naval Reserve be filed with the Commandant of the Naval District in which the applicant resides. The address of the Commandant of your district may be obtained from the Dean of your college.

Application forms may be obtained from the Dean's office or from someone designated by him, upon request from the Bureau of Medicine and Surgery, Navy Department, Washington, D. C., or from the Commandant of your Naval District. When your application form has been properly completed, it, together with the other credentials indicated on the application form, should be mailed to the Commandant of your Naval District. He will instruct you relative to obtaining a physical examination, finger prints, etc.

In the case of a premedical student, it is necessary to enclose with your application for appointment a statement, signed by the Dean of a medical college, to the effect you have been accepted as a first year medical student in a Class "A" school for the next entering class.

It is the understanding of the Bureau of Medicine and Surgery that Selective Service Boards will accept a statement from the Commandant of your Naval District to the effect that your application is on file, as basis for deferment until your application has received final action.

A Page of Medical History

A chronicle of Wisconsin's part in World War I appeared in *Wisconsin's War Record* by Fred L. Holmes of Madison, one of the better known Wisconsin authors. Mr. Holmes has since written *Abraham Lincoln Travelled This Way, Alluring Wisconsin, Badger Saints and Sinners,* and *The Voice of Trappist Silence,* as well as other volumes of historical significance. The following chapter from *Wisconsin's War Record* is reprinted, with the permission of the author, as an item of current interest.

Physicians and Nurses

THE part Wisconsin physicians played and the record they made in the war is one of which all are proud. It is exceeded only by Pennsylvania, and the supply of physicians in that state was so much greater per population and per square mile that Wisconsin may easily lay claim to having made the best record of any state in the Union, all things taken into consideration.

"I think that we were the only body of men who anticipated the war and prepared for it in advance," says Dr. Rock Sleyster of Waupun, secretary of the Wisconsin Medical Society and aide to Governor Philipp by appointment of the Surgeon General. He holds the military rank of major.

"Ten months before our country became involved, a 'Wisconsin Committee of Medical Preparedness' was formed, of which Dr. Edward Evans of La Crosse was chairman and I was secretary. This committee at that time made a survey of the medical and hospital resources of the state and got the information in shape to use in case we were drawn into this great conflict, as it was realized that medical men would be among the first to be called upon.

"This committee was later taken over by the Council of National Defense as the 'Wisconsin Committee, Medical Section, Council of National Defense,' and still later when the State Council of Defense was formed with Dr. J. S. Evans of Madison as the medical member, this committee was taken over by this body as a medical section; Dr. J. S. Evans was elected as vice-chairman and later became chairman on Dr. Edward Evans leaving for Red Cross work in France.

Sleyster Was Medical Aide

"My assignment as medical aide to the governor by the Surgeon General, in connection with the selective service work, in November, 1917, kept all of the medical organization work in the state in the office of the secretary of the State Medical Society.

"This committee also acted as a recruiting agency for the Medical Corps and examinations were given at Ashland, Milwaukee, and at Waupun."

It was realized early in the war that the demands of the government would be such as to tax the medical profession to its limit, and unless carefully handled would seriously jeopardize the medical needs of the communities of the state. Another careful survey was made and full information on each physician in the state was obtained. This showed the actual needs of his community, how many dependents he had, his qualifications, his age, his physical condition, his specialty, etc.

Maps were prepared which gave the number of square miles covered by each physician and the population he served. By this means, the state authorities were enabled to advise the enlistment of men who would be of value to the service and who could be spared by their families and by their communities. Others were advised to remain at home until the need should become greater.

Aiding Local Communities

The information on each physician was carefully card-indexed and cross-indexed and a scheme of classification as to the man's availability was worked out. Physicians were

also card-indexed according to their specialties. These indexes were kept carefully up-to-date throughout the period of the war and all information regarding any physician in the state and the needs of any community was instantly available.

An exchange was also conducted in Dr. Sleyster's office to which all physicians disqualified for service and willing to substitute in order to relieve some man for military duty were invited to send their names. By this means, it was many times possible to secure a practitioner for a community without medical help, and often the medical aide was able to supply a disqualified man to take over the work of some man fit to enter the service but unable to do so because of the needs of his community.

Physicians Send 27 Percent

A checking of the records on December 16, 1918, shows that out of a medical population of 2,814, seven hundred and fifty-four Wisconsin physicians had been called into active service. This is 27 percent of the entire number of physicians registered to practice in the state. It is fully one-third of the graduate physicians who were engaged in active practice at the beginning of the war and is more than half of those who, age and physical condition considered, were qualified for service. A study of the state medical survey shows that three of the counties have given more than 40 percent of their physicians to the service; that 22 counties have given from 30 to 40 percent; that 20 counties have given from 25 to 30 percent, and that 12 counties have given from 20 to 25 percent.

In writing of the part played by Wisconsin physicians in the war program, one must not overlook the men who have for various reasons been unable to enter the service. These men have played a most important part and it has often been harder to remain at home and do routine work without glory than to enter the service. These men have had to assume the work of those who left and it has required their working almost without exception to the limits of physical endurance.

This has been evidenced by a tripled death rate among physicians during the year 1918. In many communities the physicians who have been left at home have patriotically turned over to the families of those absent in the service a percentage or all of the fees collected for work done for their patients.

Seven hundred of the men left at home have been engaged in making physical examinations for the various local and medical advisory boards and, as a rule, without compensation of any kind.

The record made by Wisconsin medical men in France is one of which all can be justly proud. The medical organization of the 32nd Division, which has been commanded by Colonel Gilbert E. Seaman of Milwaukee, has been acknowledged and recognized as the best "Over There," and Colonel Seaman's work has been recognized recently by their giving him an entire corps. Base Hospital 22, organized, financed and equipped in Milwaukee, has been on the job twenty-four hours a day through the thick of the fighting in the late summer and fall of 1918 and has covered itself with glory.

A letter received from France tells that Major W. F. Lorenz and his field hospital, organized at Madison, have been doing splendid work. Research work by Major J. L. Yates of Milwaukee has been recognized by both the French and British governments.

The Wisconsin State Board of Health contributed three of its members to army medical service. Lieutenant William F. Whyte, Madison, its President, served at Fort Benjamin Harrison and at Camps Custer, Greenleaf, and Dix. Lieutenant Otho Fiedler, Sheboygan, aided in organizing a Base Hospital unit at Milwaukee and served with it in France. Lieutenant C. A. Richards, Rhinelander, the third army member, also served in France.

Nurses in Service

The devotion of Cordelia Harvey, widow of Gov. L. P. Harvey, Mrs. Susannah Van Valkenburg, Oshkosh, Mrs. Helen B. Cole, Sheboygan Falls, Mrs. H. D. Squire, Sheboygan, as nurses to the boys of the North during the Civil War has found its counter-page in the achievements of the 404 Red Cross nurses from Wisconsin in the great war. Many cities in the state sent units of nurses for service overseas and to cantonments in

the United States. Madison, for example, a city of third class, provided thirty.

Highly interesting letters have come from France describing conditions under which Red Cross nurses work. Typical among the many letters read by the author of this volume, is one from Miss Emily Barber, daughter of the late Charles Barber, a pioneer Oshkosh lawyer.

Speaking of her daily routine and other features of her recreation work, in November 1918, Miss Barber wrote:

"You have no idea what a busy life we lead, for now that the Red Cross has appeared, everyone from the cook to the commanding officer feels that all odd jobs can be turned over to her. I have spent all day arranging a sort of a ten-cent store, soap, washcloths, etc. We deal in everything I can imagine. I have had five or six men opening boxes for eight hours a day. I certainly never realized what steady work was before—not hectic, periodic attacks but every moment full each day. I am now sitting by a little stove, which burns very badly, with all my heavy clothing on. October came in with all the pep of December 25. If the temperature declines rapidly with the appearance of real winter I think I shall wear a feather bed. Fortunately I am so busy all day that I keep fairly warm and as I sleep between two featherbeds I don't need to suffer when I return to my funny little room. Every morning I go to the eleven wards and get lists from nurses in charge of articles needed and then I go back to my office and fill and deliver these orders.

"While delivering them I talk to the bed patients. In this hospital are many patients suffering from a milder form of shell shock who are up and about. I take down dozens of notes, secure data on lost baggage and write business letters to Paris. Then I go over to the hut and see that the magazines are distributed, hunt up a movie man, who puts on four productions a week, detail men to sweep the floor, etc. All in all, it is the first time I have had a great big work and although it is heaps too big for me I am bound to grow to meet it. This morning we got two bales of sweaters and there was a regular riot, for the boys were half frozen, many of them having lost everything they had owned. It is just glorious to give things out and they all simply adore Red Cross."

Train Emergency Nurses

That Miss Jean Webster, head nurse at the clinic of the University of Wisconsin could be relieved for service in France, Mrs. F. C. Rinker, a former nurse, and wife of Dr. Rinker of the clinic staff, volunteered for services during the 1918 influenza epidemic and directed the nursing of upwards of 1,000 S.A.T.C. boys from all sections of the state who had contracted the disease.

The legislature recognized that the calls for nurses in France would mean a grave danger of epidemics at home. It provided special training for emergency nurses. Hospitals were solicited and three of them, the Milwaukee County Hospital, the St. Agnes Hospital at Fond du Lac and the St. Mary's Hospital at Green Bay agreed to undertake the training of high school girls for nurses. When classes were opened more than sixty girls, representing every section in Wisconsin, had answered the call. These volunteer nurses were of invaluable service in combating the epidemic which in the month of October, 1918, alone took 2,600 lives of Wisconsin people as compared with about 150 in similar period in recent years.

MEDICAL OFFICERS NAMED

Dr. John S. Coulter, associate professor of physical therapy at Northwestern University Medical School, Chicago, has been appointed Regional Medical Officer of the Sixth Civilian Defense Area. The Sixth Corps Area includes Illinois, Michigan and Wisconsin.

Dr. Robert E. Fitzgerald, Milwaukee, chairman of the State Medical Society's Committee on Medical Defense, has been appointed as state chairman for the Procurement and Assignment Service. This service, established by President Roosevelt, will aid in determining proper distribution of physicians for supplying the needs of the armed forces and the civilian population.

THE WISCONSIN MEDICAL JOURNAL

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Annual Subscription--------Three Dollars-Fifty Cents Single Copies--------Fifty Cents

Advertising Representative: Cooperative Medical Advertising Bureau, 535 North Dearborn St., Chicago, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, Madison

Volume 41 FEBRUARY, 1942 Number 2

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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« « « EDITORIAL » » »

Filling in the Ranks

AT A TIME when more and more of our members will take their places beside those who have answered earlier calls for military service, it becomes increasingly important that the ranks of the Society at home be solidified and embrace all those who are eligible for participation in the many activities of the Society.

The organized medical profession in Wisconsin, of course, will give its utmost in the armed forces and in the great effort of civilian defense which affects every community in our state. This public service will tax the facilities of your Society,—many times to the straining point. This new effort will be added to the numerous normal activities of the Society, such as public health education through the individual physician and medical societies, and postgraduate medical education through the medium of the annual meeting, *The Wisconsin Medical Journal,* and the spring clinics. Our war efforts and responsibilities will accelerate other activities of the Society, such as those in the field of the Committee on Industrial Health, the Committee on Nursing Problems, the Committee on W. P. A. Health Projects, and others.

To carry out this program and to assure the greatest possible protection to the public health and the profession alike, we must count among our members all those who are eligible. As one more contribution to the health and welfare activities, each physician at home can render signal service to his profession and the public health by bringing into the Society eligible physicians to fill the gaps created by those who have left for active service, that they may help in adding to this Nation's proud record of achievement.

. . . . THE PRESIDENT'S PAGE . . . .

The New Secretary

MR. CHARLES H. CROWNHART

WHEN the Council of the State Medical Society of Wisconsin, at its annual meeting on January 10, in Milwaukee, selected Charles H. Crownhart as the secretary of the Society, a decision of the first magnitude was reached as it affects the membership of the Society and the very Society itself. No more important duty had been placed upon the Council in many years than that which became necessary in replacing the loss created by the untimely passing of J. George Crownhart.

The wisdom of the Council in not acting hastily in filling the vacancy is borne out by the smoothness with which Society affairs have functioned during the last eight months, and, more particularly, during the busy days of the centenary celebration in September. As stated elsewhere by your president, this is indeed a tribute to the loyalty and devotion of an office staff trained over a period of years under an efficient and brilliant leader. As a result, through the forceful direction of the acting secretary, George B. Larson, to whom the Society will ever be grateful, a minimum of disturbance was created during the transition period.

The task of choosing a secretary was made easier as the result of the conscientious work of the committee, representative of the entire profession of the state, which was appointed by the chairman of the Council. To this committee—composed of Robert W. Blumenthal, Milwaukee, representing the Council; Russell M. Kurten, Racine, speaker of the House of Delegates, representing this body; Carl W. Eberbach, president of the Medical Society of Milwaukee County, the largest county society in the state organization; Clair O. Vingom, Madison, representing the second largest county society; and your president—was assigned the duty of reviewing the voluminous material which had accumulated for the purpose of making a recommendation. Acting upon the suggestion of this committee, by unanimous vote the Council selected Charles H. Crownhart.

To the secretary of the Society, and to his office, falls the all-important job of carrying out the mandates of its membership. In consequence thereof the secretaryship is the most important position in the Society structure. It is the opinion of your president that the Council has been most foresighted in its judgment and in its final selection. As time goes on, it is my prediction that as far as the membership of our Society is concerned, it will be aware only of the fact that the secretary's initials have been changed. No greater compliment could be paid George's successor.

The Society is to be congratulated in securing the services of Charlie, and, on behalf of our new secretary, I bespeak the earnest cooperation of our membership.

Gunnar Gundersen

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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The Bulletin

By MRS. CHARLES FIDLER
Milwaukee

THE Woman's Auxiliary has grown until it has a membership of over 27,000. American medicine has elevated the standards of public health in this country far above those of any countries using other systems of practice. Developments which threaten to destroy these achievements confront us, and it is the duty of the members of the Woman's Auxiliary, as well as the officers and chairmen who manage its affairs, to be well informed concerning the ideals and policies of our organization. They should also keep abreast of the times regarding those questions which are of interest to the medical profession.

The *Bulletin* is the official publication of the Woman's Auxiliary to the American Medical Association, just as the *Journal of the American Medical Association* is the official publication of the American Medical Association. From now on official programs of standing committees will be printed in the *Bulletin* instead of in leaflets as formerly. This plan will eliminate much printing and postage expense. The program will reach state and county officers at the same time, making it easier for state officers to plan the work with the officers of county auxiliaries early in the summer. All officers will have just one pamphlet for reference instead of several, which will also mean greater coordination of effort and less overlapping in planning program activities.

Besides the programs, each issue of the *Bulletin* will contain information relative to home defense measures, nutritional education, or Pan-American unity. The Committee on Press and Publicity promises interesting and valuable material for each issue.

The *Bulletin* is an important aid for all who are actively engaged in the work of the Auxiliary, particularly this year because of the defense program. County presidents have been asked to appoint chairmen for the promotion of our official publication. It is the wish of Mrs. J. S. Supernaw, state president, that all state and county officers and committee chairmen subscribe to the *Bulletin*.

The above suggestions from Mrs. Charles H. Werner, circulation manager, should increase our earnest cooperation in the circulation of the *Bulletin*.

TWO NEW SECTIONS

The attention of Auxiliary members is called to two new sections now appearing in *The Journal*. The first is a series of articles on nutrition (see page 124), and the second is entitled "The Nation at War" (see page 129).

Philanthropic Work

By MRS. J. W. MacGREGOR
Portage

PHYSICIANS' hours are long, it is true. But gone are the days when their wives sat with folded hands. Today they are as busy as their husbands filling the hours with the study of proper nutrition, public health work, and the Women's Field Army of the American Society for the Control of Cancer. That they are finding practical ways of helping these projects to thrive is evident in their reports to me. I wish it were possible to publish all of these reports. You would then be convinced that, if the physician's wife was ever accused of idleness, this is no longer true.

As one thinks of national defense work, one can almost hear the click of knitting needles and the gentle purr of electric sewing machines turning out garments, and see the hundreds of bandages being rolled and packed, and the many infants' garments being made for the Visiting Nurses Association, the many orphanages and hospitals, the Red Cross and other worthy institutions and organizations in this great state.

Donations of money, necessities and, best of all, many luxuries, such as flowers, playing cards, toys, candies, magazines and cigarettes are being given to these same institutions and to our men in service in army hospitals.

Needy Girl Scout Troops are being provided with funds for their projects. Many of our members are volunteer workers in the Girl Scouts.

Many schools and libraries are being furnished with *Hygeia*, providing numberless people with reading material on the subjects of health and proper nutrition.

Crippled and needy children are given vacations in camps, and orthopedic appliances are provided for many of them.

Yes, indeed—the physicians' wives of this state are not idle. They are doing many constructive things in a philanthropic way and will continue their helpfulness as long as there is need.

County Auxiliary Proceedings

Brown—Kewaunee—Door

The Woman's Auxiliary to the Brown–Kewaunee–Door County Medical Society met on January 16 at the home of Mrs. J. P. Lenfestey, De Pere. The guest speaker was Mrs. Lawrence P. Works, a graduate in home economics from the University of Wisconsin and a former Green Bay high school teacher, who will conduct classes in defense nutrition at Green Bay. The subject of her address was "Defense Nutrition."

Dane

The Woman's Auxiliary to the Dane County Medical Society had a luncheon meeting on January 12 at 1 p. m. at the home of Mrs. H. E. Marsh of Madison. Twenty-five members and two guests were present. Mrs. F. K. Dean, chairman of the luncheon committee, was assisted by Mmes. D. C. Atwood, J. T. Sprague, C. A. Fosmark, and E. H. Grumke.

Mrs. P. A. Hauver gave an instructive talk on "America Needs Plain and Straightforward Nutrition." Miss B'Ann Blied, daughter of Mr. and Mrs. Leo Blied, played several piano selections.

Mrs. W. C. Keettel reported that she had been able to arrange for sixty *Hygeia* subscriptions for schools.

Mrs. Marsh explained the need for books for men in service. Members were told to take books appropriate for men to the Public Library where they will be collected by the American Library Association, Red Cross, and U. S. O. for distribution.

Mrs. N. A. Hill is to represent the group on the local defense council headed by Dr. C. O. Vingom of Madison.

Kenosha

"Opportunities for Service with the American Red Cross" was the title of a report read to the Woman's Auxiliary to the Kenosha County Medical Society at its regular monthly meeting on January 6 by Miss Norabelle Binnie.

The meeting took place at the home of Mrs. A. L. Mayfield, Kenosha, with Miss Binnie and Mrs. C. F. Ulrich as the assisting hostesses. The group voted to set aside one day on which the members would work for the Red Cross.

Mrs. L. H. Lokvam, president, presided at the tea table for the refreshments which were served after the business session. Twenty members were present.

Manitowoc

The Woman's Auxiliary to the Manitowoc County Medical Society held its November–December meeting at Dill's Tea Room, Manitowoc, on December 10. The meeting was in the form of a Christmas party. Mrs. F. E. Turgasen gave a book review on *The Doctors Mayo* taken from the *Atlantic Monthly*.

The Auxiliary subscribed to the *Bulletin*. The *1941–'42 Yearbook*, compiled by Mrs. T. H. Rees, shows an interesting program for the year, including the study of proper nutrition and public health. Officers and committees are listed as follows:

President—Mrs. E. C. Cary, Reedsville
President-elect—Mrs. Nathan Schneck, Manitowoc
Secretary–treasurer—Mrs. C. E. Wall, Manitowoc
Program—Mrs. T. H. Rees and Mrs. T. A. Teitgen, Manitowoc
Public relations—Mrs. H. J. Belson and Mrs. R. G. Strong, Manitowoc
Press and publicity—Mrs. L. D. Sobush, Manitowoc, and Mrs. R. E. Martin, Two Rivers
Hygeia—Mrs. E. W. Huth, Mishicot
Social—Mrs. W. H. Scherping and Mrs. A. F. Stueck, Manitowoc
Membership—Mrs. M. P. Andrews, Manitowoc
Archives—Mrs. F. W. Hammond, Manitowoc
Constitution—Mrs. W. E. Donahue, Manitowoc
Telephone—Mmes. G. M. Hoffman, R. G. Yost, A. J. Shimek, and J. W. Steckbauer, Manitowoc, and Mrs. A. W. Kozelka, Two Rivers.

A social hour, during which games were played, followed the business meeting. Hostesses were Mmes. H. J. Belson, N. C. Erdman, and W. E. Donahue.

The Auxiliary has a membership of thirty-five, and regular meetings are held the third Wednesday of the month.

The Auxiliary regrets the passing of Mrs. C. J. Skwor of Mishicot, who died on December 3 at the Holy Family Hospital, Manitowoc, following a long illness.

Marinette—Florence

At the meeting of the Woman's Auxiliary to the Marinette–Florence County Medical Society on January 9 at the home of Mrs. H. L. Jorgenson, Marinette, the group voted to donate $25 to the Red Cross war relief fund. Following the business session there was a social hour. The next meeting will be held on Monday, March 2, at the home of Mrs. J. D. Zeratsky, Marinette.

The new officers of the Marinette–Florence Auxiliary are Mrs. Haldor Barnes, president; Mrs. J. D. Zeratsky, president-elect; Mrs. R. W. Shaw, secretary, and Mrs. H. L. Jorgenson, treasurer.

Milwaukee

The Woman's Auxiliary to the Medical Society of Milwaukee County celebrated its tenth anniversary with a luncheon at the Hotel Schroeder on December 12. One hundred sixty-five members and guests were present, among them many charter members who were especially invited to the meeting. During the luncheon a group of members entertained the women with Christmas carols. Mrs. Lorna Warfield conducted the singing and the Mmes. G. E. Thill, E. M. Lawler, and G. F. Kelly accompanied on the violins and piano.

After the luncheon, the president, Mrs. R. D. Champney, introduced the women who were responsible for organizing the Auxiliary, and asked the charter members to rise in a body.

Mrs. Elsie Redmond of the Red Cross then explained the various fields open to volunteers who wish to help the Red Cross during the emergency. Mrs. A. R. Langjahr and Mrs. W. A. Joseph will act as chairman and co-chairman of the newly organized Red Cross committee. Mrs. W. C. Liefert has been appointed by the president as chairman of the civilian defense work. Both chairmen are anxious to have as many volunteers as possible.

The business meeting followed. Mrs. L. B. Uszler read the minutes which were accepted. The membership chairman introduced the following new members: Mmes. S. M. Evans, L. L. Fifrick, J. D. Owen, T. J. Howard, W. A. Langmack, B. J. Peters, and C. W. Hughes.

The secretary read the proposed revision of the By-laws. A member dropped for non-payment of dues will be required to pay the dues for the year in which she was dropped in addition to those for the year she is reinstated. In the proposed revision the following words shall be inserted after the word "required," "to make re-application for membership and." Mrs. W. C. Liefert made a motion to accept the revision of the By-laws, and the motion was carried.

Mrs. J. S. Supernaw, state president, who was a luncheon guest, encouraged the group to do its utmost in helping the Red Cross expand its program to meet the requirements of the present emergency.

The program chairman, Mrs. R. E. McDonald, then took charge of the meeting. First, a skit was given by the members and Miss Weiler to acquaint the group with the work being done by the committee working with the Visiting Nurses Association. The portrayal was humorous, but left no one in doubt about the fine work being accomplished by the committee. Credit must be given to Mrs. M. C. Borman who wrote and directed the skit.

Mrs. Joseph Gramling then spoke on the background of the Auxiliary to the State Medical Society and the origin of the Milwaukee County group. Mrs. J. C. Sargent, first Milwaukee Auxiliary president, gave a history of the organization. Both talks were extremely interesting.

On January 9, the Milwaukee Auxiliary held its monthly meeting with a luncheon at the Pfister Hotel. Despite extremely cold weather, sixty-five members were present. American flags replaced the usual floral decorations.

The president, Mrs. R. D. Champney, greeted the members and announced the business meeting. The secretary's minutes were read and approved. The treasurer's report was read and placed on file. The following chairmen gave reports:

Mrs. A. R. Langjahr, membership and Red Cross chairman, reported three new members: Mrs. R. M. Fellows, Mrs. J. B. Ludden, and Mrs. H. W. Pohle. She also reported that Mrs. W. A. Joseph, co-chairman, had resigned because of illness in the family, and that Mrs. T. M. Northey had been appointed to replace her. The Red Cross committee and volunteers are to meet in Room 930 of the Bankers Building between 10 a. m. and 4 p. m. every Friday.

Mrs. E. J. Behnke, chairman of the education committee, explained what her committee was doing to eliminate medical quackery in Milwaukee County.

Mrs. H. A. Cunningham, chairman of the telephone committee, told of her committee's work in contacting members for Red Cross and civilian defense work.

Mrs. W. C. Liefert, civilian defense chairman, asked for volunteers to organize a motor corps. She explained the need for such a group.

It was announced that the card party on February 6 at Tripoli Temple, the proceeds from which are to be donated to the Red Cross, is to be in charge of Mrs. H. O. Zurheide.

The meeting was then turned over to the program chairman, Mrs. R. E. McDonald. Mr. Irving Schwerke, musician, critic and teacher, was the guest speaker, his topic being "Twenty Years of Musical Life in Paris." Mr. Schwerke told many anecdotes about famous people and delighted his audience. He said he had planned to spend three years in Paris and stayed on for twenty-one years. Following this interesting program the meeting adjourned.

Racine

Dr. Florence MacInnis, head of the tuberculosis division of the Milwaukee Health Department, spoke to members of the Woman's Auxiliary to the Racine County Medical Society on January 12 at the home of Mrs. W. C. Hanson, Racine. In discussing the value of education in the control of disease, Dr. MacInnis emphasized the need of care in handling foods. Knowledge rather than fear, she said, should prompt examinations in cases of suspected tuberculosis.

During the meeting the members did Red Cross work.

Spring blooms decorated the tea table, at which Mrs. R. D. Jamieson, president, and Mrs. E. W. Schacht, immediate past-president, poured. Assisting hostesses were Mmes. F. C. Christensen, H. C. Hilker, C. K. Hahn, P. R. Hahn, S. J. Faber, and L. M. Lifschutz.

Rock

Twenty members of the Woman's Auxiliary to the Rock County Medical Society brought numerous gifts to their luncheon meeting at the Woman's Club on December 16 to be distributed Christmas Day to patients at Pinehurst Sanatorium. This is an annual project of the organization.

An interesting review of Alice Duer Miller's "White Cliffs" was given by Mrs. W. A. Munn, Janesville.

The group voted, in a business meeting, to offer its services where needed in civilian defense.

Twenty-five cent gifts were exchanged by members.

Sheboygan

The importance of expressing one's own individuality and personality in decorating a home was mentioned by J. Nelson Jung in his talk on interior decoration given on January 14 at the meeting of the Woman's Auxiliary to the Sheboygan County Medical Society. The hostess was Mrs. G. J. Hildebrand, Sheboygan, and assisting hostesses were Mmes. Ludwig Gruenewald and W. W. Van Zanten, Sheboygan.

Washington—Ozaukee

The Woman's Auxiliary to the Washington–Ozaukee County Medical Society met at the home of Mrs. M. E. Monroe, Hartford, for a dessert bridge on December 11. Thirteen members and one guest were present.

Mrs. A. H. Barr of Port Washington took charge of the program, assisted by Mrs. K. T. Bauer of West Bend. A collection was taken for the purpose of providing Christmas cheer for some needy family.

The playing of contract bridge followed the program. The prizes were won by Mmes. A. H. Heidner and H. M. Lynch of West Bend.

It was announced that the next meeting would be a luncheon in March at West Bend.

Waukesha

Twenty members of the Woman's Auxiliary to the Waukesha County Medical Society braved a twenty-below-zero temperature to meet at the Avalon Hotel, Waukesha, on January 7. The business meeting was called to order by the president, Mrs. T. H. Nammacher. The minutes of the December meeting were read and approved. The treasurer's report was read.

Mrs. G. W. Brewer, Hartland, chairman of *Hygeia*, gave her report. Due to finances, the question was raised of whether the full quota of *Hygeia* subscriptions should be placed. After some discussion, the motion was made by Mrs. J. B. Noble that the subscriptions be placed so that the *Hygeia* contest could be entered. The motion was carried.

In the absence of the philanthropic chairman, Mrs. Nammacher reported that the gifts to the boys at the Wisconsin Home and Farm School were greatly appreciated.

Reporting for the history committee, Mrs. Noble stated that the photographs of physicians are now completed and will be ready to file as soon as mounted. Photographs of the very earliest physicians in the county were found among old records in the historical room.

A communication from Mrs. J. S. Supernaw, state president, was read. She asked that a member from the county auxiliary be appointed to work with Dr. H. T. Barnes of Delafield, county medical society civilian defense chairman.

Mrs. Nammacher read a letter she had received from Mrs. W. D. James, an Auxiliary member, who at present is living in Weatherford, Texas, where Dr. James is in army service.

After adjournment of the business meeting, Auxiliary members met with members of the Medical Society to hear Mr. James O. Kelley, executive secretary of the Medical Society of Milwaukee County, speak on emergency medical service in the civilian defense program. Mr. Vernon Gaspar, chairman of the civilian defense committee for Waukesha County, briefly outlined the work of his committee.

Society Proceedings

Barron—Washburn—Sawyer—Burnett

Members of the Barron–Washburn–Sawyer–Burnett County Medical Society held a dinner meeting at the Land O'Lakes Hotel, Rice Lake, on January 22. Those present enjoyed two lectures, which were illustrated by kodachromes. Dr. Stephan Epstein, Marshfield, spoke on "Management of Common Skin Diseases in General Practice" and Dr. L. A. Copps, Marshfield, discussed "Differential Diagnosis of Conjunctival and Ciliary Infection of the Eye."

The meeting was well attended.

Brown—Kewaunee—Door

The assistant medical director of Eli Lilly and Company, Dr. F. E. Peck of Indianapolis, Indiana, discussed "Newer Aspects of Diabetes" at the meeting of the Brown–Kewaunee–Door County Medical Society at the Northland Hotel, Green Bay, on January 8. This presentation was greatly enjoyed by the thirty-four doctors present, as well as by the nurses from the local hospitals who were invited to attend.

Chippewa

Twenty-five members of the Chippewa County Medical Society had a dinner meeting at the Hotel Northern, Chippewa Falls, on January 13. Present also were several guests from the Eau Claire–Dunn–Pepin and the Barron–Washburn–Sawyer–Burnett County Medical Societies.

Following the dinner two guest speakers from the University of Wisconsin Medical school presented papers. Dr. J. E. Gonce, Jr., professor of pediatrics, spoke on "Urinary Infections in Childhood," and Dr. J. B. Bingham, instructor in medicine, discussed "Thrombosis."

Columbia—Marquette—Adams

Fifteen members of the Columbia–Marquette–Adams County Medical Society were present at an evening meeting at the St. Savior Hospital, Portage, on January 20. This meeting was devoted to a discussion of the duties of the Society in the emergency medical service. Also at this time the members expressed a willingness to cooperate with the Women's Field Army in their fight against cancer.

Dane

Fifty members attended the meeting of the Dane County Medical Society at the Madison Club on January 13, and heard lectures by two local doctors. Dr. H. C. Slocum, instructor in anesthesia, at the University of Wisconsin Medical School, presented a paper entitled "Relief of Pain," and Dr. J. T. F. Gallagher lectured on "Ethyl Chloride Treatment of Acute Sprains."

A very interesting feature on the program was the presentation by a Parke, Davis and Company representative of an excellent color sound movie entitled "Sex Hormones, Diagnosis and Therapy." This sound movie was reported by those in attendance to be very entertaining, and of a non-advertising nature.

Dodge

On December 30 Dr. F. G. Bachhuber, Mayville, was host to members of the Dodge County Medical Society at a dinner at his home. As this was planned to be a social evening, no scientific program was scheduled.

Douglas

On January 14 a 6:30 dinner meeting was held by members of the Douglas County Medical Society at the Androy Hotel, Superior. Dr. C. H. Mead, Duluth, the guest speaker, discussed "Diseases of the Appendix." Fifteen members were in attendance.

Fond du Lac

Dr. W. C. Keettel, special instructor in obstetrics and gynecology of the Bureau of Maternal and Child Health of the State Board of Health, Madison, was the guest speaker at the Fond du Lac County Medical Society meeting on January 22. This was a dinner meeting held at 6:30 p. m. at the Retlaw Hotel, Fond du Lac, at which thirty-eight members were present. Dr. Keettel spoke on "Indications for Forceps Delivery and Cesarean."

Jefferson

The scientific program of the meeting held by the Jefferson County Medical Society at Forest Lawn Sanatorium, Jefferson, on January 22, consisted of lectures by three doctors from the University of Wisconsin Medical School. Dr. J. J. Halbert, junior resident in medicine, spoke on "Newer Instruments Used in the Surgical Treatment of Pulmonary Conditions." Dr. R. B. Larson, junior resident in surgery, reported on "A Case of Extrapleural Pneumolysis." Dr. W. H. Oatway, Jr., assistant professor of medicine, gave a lecture entitled "Methods of Segregating Tuberculous Patients in a General Hospital."

After a short business session the meeting adjourned.

The meeting was well attended, with twenty-six present.

La Crosse

Dr. S. F. Haines, associate professor of medicine at the Mayo Foundation, Rochester, was the guest speaker at the monthly meeting of the La Crosse County Medical Society, which was held at the Stoddard Hotel, La Crosse, on January 15 at 6:30 p.m. Dr. Haines addressed the members on "Management of Thyroid Disease and Exophthalmia." Forty-seven members were in attendance at this meeting.

Langlade

The newly elected officers for the Langlade County Medical Society for 1942 are: Dr. W. P. Curran, president and alternate delegate; Dr. J. W. Lambert, secretary; and Dr. C. E. Zellmer, delegate. All are of Antigo.

Manitowoc

"Drugs, Ethical and Unethical," was the subject of the address by Dr. P. C. Barton, Chicago, before a joint noon-day luncheon of the Manitowoc County Medical Society and the Manitowoc County Dental Society, held at Hotel Manitowoc on January 8. Dr. Barton is director of the Bureau of Investigation of the American Medical Association, in which capacity he has served since 1934.

Marinette—Florence

Members of the Marinette–Florence County Medical Society met at Hotel Menominee, Menominee, Michigan, on January 19, in conjunction with the Menominee County Medical Society. Dinner was served at 6:30 p. m., after which those present enjoyed an address by Dr. J. R. Miller, dean of Northwestern University Medical School, who discussed certain phases of the civilian defense program.

Invited to attend this meeting were members of Marinette and Menominee service clubs, Red Cross and defense committees.

Milwaukee

Members of the Medical Society of Milwaukee County held a meeting at the Milwaukee Athletic Club at 8:30 p.m. on January 9. After fifteen minutes' discussion of preventive medicine, a scientific program comprising two lectures pertaining to medicine in wartime was presented. "Army and Navy Blood Plasma Bank" was the title of the address presented by Dr. M. A. Hardgrove, Milwaukee. Dr. W. D. Stovall, professor of hygiene, University of Wisconsin Medical School, and director of the State Laboratory of Hygiene, Madison, presented a paper entitled "Laboratory Medicine in War."

Oconto

Dr. W. R. Berg, Gillett, was re-elected president of the Oconto County Medical Society at the December meeting held in Oconto Falls. Dr. C. R. Kwapy, Oconto, was re-elected secretary and treasurer.

The January meeting of the Society was held at the Alamo Club, on the sixteenth. Mr. G. B. Larson, assistant secretary of the State Medical Society of Wisconsin, presented the film strip "Health Achievements in Wisconsin." He also discussed the purposes and applications of the film strip. Part of the meeting was devoted to the discussion of the medical care of Farm Security Administration clients.

Outagamie

The monthly meeting of the Outagamie County Medical Society was held at the Conway Hotel, Appleton, on January 22. "War Neuroses" was the topic of the address by Dr. L. J. Pollock, professor of nervous and mental disorders, Northwestern University Medical School, who was chosen as the guest speaker.

Racine

The regular meeting of the Racine County Medical Society was held on January 15 at the Elk's Club, Racine. The speaker of the evening was Dr. R. E. Fitzgerald, Milwaukee, a member of the

health and welfare section of the State Council of Defense, representing emergency medical service, and chairman of the State Society's Committee on Medical Defense. He spoke on "Mobilization and the Status of the Doctor." The meeting was well attended and several doctors from Kenosha, Burlington and Lake Geneva were present.

At the December meeting of the Society Dr. K. W. Covell, Racine, was elected to full membership.

Trempealeau—Jackson—Buffalo

Dr. J. M. Stickney, instructor in medicine, Mayo Foundation, Rochester, was the guest speaker for the members of the Trempealeau–Jackson–Buffalo County Medical Society at their monthly meeting at Ettrick on January 15.

Also included on the program was Dr. R. L. MacCornack, Whitehall, who presented a moving picture on cesarean section.

Dr. H. A. Jegi, Galesville, reported on the councilors' meeting held in Milwaukee, and announced the selection of Mr. C. H. Crownhart, Madison, as secretary of the State Medical Society of Wisconsin.

Fourteen members were in attendance at this meeting.

Vernon

The Vernon County Medical Society meeting was held at the Oriole Cafe, Viroqua, on December 12.

Dr. W. E. Bannen, La Crosse, addressed the members on "You and the Doctor." Other features of the program were a showing of the film "Health Achievements in Wisconsin," a film prepared under the direction of the Committee on Health and Public Instruction, and a movie on skin grafting.

At a business session the following were elected to office for the ensuing year: Dr. A. E. Kuehn, Viroqua, president; Dr. H. Gulbrandsen, Viroqua, vice-president; Dr. C. M. Strand, Westby, secretary-treasurer; Dr. W. M. Trowbridge, Viroqua, delegate; and Dr. J. J. Rouse, Hillsboro, alternate delegate.

Walworth

A meeting of the Walworth County Medical Society, at which members of the Woman's Auxiliary were guests, was held at the Colonial Inn at Darien on January 8. This meeting was also a farewell party for Dr. and Mrs. L. H. Donath, Lake Geneva, who were leaving on January 15 to make their home in Milwaukee.

Winnebago

A dinner meeting was held by members of the Winnebago County Medical Society at the Valley Inn, Neenah, on January 8. The scientific program following the dinner consisted of an address by Dr. W. M. Kearns, clinical instructor in urology at Marquette University School of Medicine. The title of his address was "Urinary Stone Formation in Recumbent Patients." An open discussion on endocrinology followed Dr. Kearns' address.

Thirty-five members were present.

Ninth Councilor District

About forty doctors from counties comprising the Ninth Councilor District Medical Society attended the meeting of the Society at Hotel Witter, Wisconsin Rapids, on January 15. Two speakers from the University of Wisconsin Medical School presented the scientific program which followed the 6 o'clock dinner. Dr. A. R. Curreri, assistant professor of surgery, spoke on "Chest Injuries," and Dr. K. L. Puestow, associate professor of medicine, discussed "Diagnosis and Treatment of Cardio Spasm and Allied Conditions."

Milwaukee Academy of Medicine

The annual meeting of the Milwaukee Academy of Medicine was held at the University Club at 6:30 p.m. on January 20. The speaker was Dr. E. L. Sevringhaus, professor of medicine, University of Wisconsin Medical School, who gave an account of his recent trip to South America.

At this time Dr. J. J. Pink, president-elect, was inducted into office as president of the Society. Dr. T. L. Squier was named president-elect. Other physicians voted into office for the coming year were: Dr. F. W. Madison, vice-president; Dr. E. W. Mason, secretary; Dr. Irwin Schulz, treasurer; Dr. O. R. Lillie, director; and Dr. A. A. Holbrook, chairman of the program committee.

An honorary membership was bestowed upon Dr. A. W. Gray, Milwaukee.

Milwaukee Neuro-Psychiatric Society

Dr. J. D. Camp, associate professor of radiology, Mayo Foundation, Rochester, was the guest speaker at a dinner meeting of the Milwaukee Neuro-Psychiatric Society held at the University Club on January 22. Dr. Camp addressed the group on "Radiologic Diagnoses of Neuropsychiatric Disorders."

Members of the Milwaukee Radiologic Society were invited to attend this meeting and take part in the discussion.

Milwaukee Oto-Ophthalmic Society

A dinner meeting was held by members of the Milwaukee Oto-Ophthalmic Society at the University Club on January 13. Following the dinner a clinical meeting, with presentation of cases, was held. The scientific program which was presented follows:

"Presbyopic Analysis" by A. H. Pember, M. D., Janesville.

"Dysphagia: Clinical, X-ray and Esophagoscopic Aspects" by G. D. Straus, M. D., Milwaukee.

Wisconsin Heart Association

(Section on Cardiology, State Medical Society of Wisconsin)

At the annual meeting on December 12 members of the Wisconsin Heart Association (Section on Cardiology of the State Medical Society of Wisconsin) adopted By-laws for the Association and elected the following officers:

President—Dr. A. G. Koehler, Oshkosh
Vice-president—Dr. M. A. Hardgrove, Milwaukee
Secretary-treasurer—Dr. R. F. Wagner, Oshkosh
Delegate—Dr. A. W. Bryan, Madison
Directors—Dr. A. A. Pleyte, Milwaukee (2 year term); Dr. P. B. Mason, Sheboygan (1 year term)

The following program was enjoyed by those in attendance:

Morning Program (Milwaukee County Hospital—Guests of Dr. F. D. Murphy)

9:00–10:30 Ward Walks
10:30–12:00 Clinic—Newer Aspects of Treatment of Hypertension, Including Discussion of Renal Extract

Afternoon Program (Schroeder Hotel—2 p.m.)

Business Meeting
"Coronary Threat"—Dr. A. M. Hutter, Fond du Lac
"Bundle Branch Block"—Illustrative Cardiograms—Dr. A. W. Bryan, Madison
"Cardiac Irregularities"—Dr. H. L. Correll, Wauwatosa

Banquet (Schroeder Hotel—6:30 p.m.)

Informal discussion of war problems, led by Dr. F. D. Murphy.

Wisconsin Hospital Association

All officers and directors of the Wisconsin Hospital Association were re-elected at the January mid-winter conference in the Wisconsin Hotel, Milwaukee, with the exception of Dr. R. C. Buerki, who became director of hospitals at the University of Pennsylvania and dean of the University of Pennsylvania Graduate School of Medicine in September, 1941. Dr. Buerki, who attended the conference and was honored with Mrs. Buerki at a testimonial luncheon, was formerly executive secretary of the University of Wisconsin Medical School and superintendent of the State of Wisconsin General Hospital and Wisconsin Orthopedic Hospital, Madison.

Dr. H. M. Coon, present superintendent of Wisconsin General Hospital, was elected to replace Dr. Buerki on the Association's board of directors. Other officers re-elected are the Rev. H. L. Fritschel (Milwaukee Hospital, Milwaukee), president; Sister M. Augusta (St. Joseph's Hospital, Milwaukee), first vice-president; Mr. G. F. Meyer (Medford Clinic, Medford), second vice-president; Dr. E. T. Thompson (Mt. Sinai Hospital, Milwaukee), secretary-treasurer, and Mr. J. G. Norby (Columbia Hospital, Milwaukee), director.

Wisconsin Trudeau Society

Members of the Wisconsin Trudeau Society held a meeting, consisting of afternoon and evening sessions, at Muirdale Sanatorium on January 17. The guest speakers were Drs. W. N. Feldman, Rochester, Minnesota and L. L. Collins, Ottawa, Illinois. Members were dinner guests at Muirdale Sanatorium.

POISONING FROM CADMIUM

Because of outbreaks in food poisoning, the Federal Security Agency has advised manufacturers against using cadmium, a substitute for aluminum, in plating cooking utensils and refrigerator containers, Federal Security Administrator Paul V. McNutt recently announced.

Mr. McNutt said the Food and Drug Administration and the United States Public Health Service, following an investigation of outbreaks, have found they were due to cadmium, which they said contained a poisonous substance causing severe illness when taken in food even in small amounts.

Symptoms of cadmium poisoning include acute gastritis, nausea, cramps, vomiting, diarrhea, and weakness. Illness may occur within ten minutes after eating or drinking the contaminated food. As little as 15 parts per million of cadmium may cause acute symptoms. Foods containing acids are particularly apt to be affected.

News Items and Personals

M. H. SEEVERS, M. D.

Dr. M. H. Seevers, who since the inauguration in March, 1938 of the section in *The Wisconsin Medical Journal* entitled "Comments on Treatment" has served as its co-author, on February 1 will assume the position of professor of pharmacology and chairman of that department at the University of Michigan, Ann Arbor.

Each month under the authorship of either *Dr. Seevers* or *Dr. A. J. Quick,* "Comments on Treatment," has presented the most current information on the use of the newer drugs in the treatment of disease. The preparation of this information for the profession has drawn heavily upon the time of both *Drs. Seevers* and *Quick.* The Society appreciates this generous contribution of time and skill, that these newer advancements in the care of patients may be made immediately available to physicians throughout Wisconsin.

Dr. Seevers came to the University of Wisconsin in 1929 as assistant professor of pharmacology and since 1934 has been associate professor. He received the degree of Doctor of Philosophy from the University of Chicago in 1928 and of Doctor of Medicine from Rush Medical College in 1932.

Besides his membership in the Dane County Medical Society, State Medical Society of Wisconsin, and American Medical Association, he is a member of the American Physiological Society; the American Society for Pharmacology and Experimental Therapeutics, on whose council he served in 1937 and 1938; the American Association for the Advancement of Science, and the Society for Experimental Biology and Medicine. He also holds honorary membership in the American Society of Anesthetists, is consulting editor in pharmacology for the journal entitled *Anesthesiology,* and is consultant in the division of mental hygiene of the U. S. Public Health Service.

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Dr. G. M. Shinners, newly appointed city health commissioner of Green Bay, officially assumed his duties on January 2. He recently took a special ten weeks' course in public health administration at the University of Minnesota.

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The reappointment of *Dr. H. L. Atkinson,* Green Bay, as city physician, was recently announced by the public welfare commission of that city.

R. H. SCHMIDT, M. D.

Dr. R. H. Schmidt, Jr., acting superintendent of the Wisconsin State Sanatorium, Statesan, since September 1, 1941, was appointed permanently to the position by the State Board of Health on January 9. *Dr. Schmidt* succeeds *Dr. H. M. Coon,* now superintendent of the State of Wisconsin General Hospital.

The State Board of Health re-elected all of its 1941 officers. They are *Dr. W. W. Kelly,* Green Bay, president; *Dr. Stephen Cahana,* Milwaukee, vice-president, and *Dr. C. A. Harper,* secretary and state health officer. Other members are *Dr. Joseph Dean,* Madison; *Dr. R. L. MacCornack,* Whitehall; *Dr. C. W. Eberbach,* Milwaukee, and Mrs. Amalia O. Baird, R. N., Eau Claire.

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Three Janesville and two Marshfield physicians recently attended the one week's course in emergency surgery at the University of Minnesota. They are *Drs. T. J. Snodgrass, W. A. Munn* and *G. C. Waufle* (Janesville) and *Drs. R. W. Mason* and *E. J. McGinn* (Marshfield).

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Dr. D. L. Dawson, Rice Lake, was elected president of the staff of St. Joseph's Hospital, Rice Lake, at a meeting on January 13. He succeeds *Dr. R. W. Adams,* Chetek. *Dr. O. E. Rydell* was re-elected secretary.

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Dr. L. D. Smith, orthopedic surgeon of Milwaukee, spoke at the meeting of the Kiwanis Club in Port Washington on January 13. He discussed the importance of proper care of the feet.

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"Contrary to popular belief, heart diseases are not increasing," said *Dr. P. B. Mason,* Sheboygan, when he addressed the Sheboygan Falls Woman's Club on January 13. He described the normal heart, the various diseases of that organ and treatments which are now being given for heart diseases.

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Dr. R. A. Thayer and *Dr. C. E. Smith,* Beloit, were speakers at the luncheon of the Lions Club, Beloit, on January 15. *Dr. Thayer* discussed the hospital's place in the present national emergency, and *Dr. Smith* discussed the proposed plasma bank.

Dr. Gail Broberg, Neenah, was the speaker at the monthly dinner meeting of the Jacettes, auxiliary to the Appleton Junior Chamber of Commerce, on January 5 at Hotel Appleton.

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Dr. R. H. Quade, Neenah, was the speaker at the January meeting of the sixth district, Wisconsin State Nurses Association, on January 7 at Neenah. His topic was "Nursing Care in Neurological Cases."

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Dr. L. H. Donath has resigned his position as city health officer of Lake Geneva due to transfer of his medical practice to Milwaukee. *Dr. E. D. Hudson* has been appointed to take over the duties of health officer.

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The first regular meeting of the staff of Mondovi Clinic Hospital was held at Mondovi on January 5. The hospital staff was organized on December 17, 1941, with *Dr. B. F. Johnson*, Mondovi, as chief of staff.

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At a recent meeting of the Marshfield P.E.O. chapter, *Dr. L. A. Copps*, Marshfield, addressed the group with a discussion on "Chemistry and Medicine."

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Dr. R. E. Garrison, Wisconsin Rapids, has assumed the office of Wood County coroner. He was appointed by Governor Heil to fill the unexpired term of *Dr. P. E. Wright*, Wisconsin Rapids, coroner for the last seven years, who resigned.

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Dr. W. W. Kelly, Green Bay, spoke on "The Importance of Public Health" at the meeting of the Green Bay Rotary Club on January 15.

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Dr. Robert J. Reuter, who has been associated with his brother in Milwaukee in the practice of dermatology, on February 2 assumed charge of the department of dermatology at the Jackson Clinic, Madison. *Dr. Reuter* has done postgraduate study at the Boston City Hospital and University of Iowa Medical School, and is a certified member of the American Board of Dermatology and Syphilology.

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Departmental chiefs of St. Mary's Hospital, Superior, were announced recently by the executive committee composed of *Dr. H. J. Orchard*, chairman; *Dr. T. J. Doyle*, secretary, and *Drs. W. H. Schnell* and *H. A. Sincock*. The departmental chiefs are as follows: orthopedic—*Dr. W. H. Schnell;* x-ray—*Dr. Charles W. Giesen;* medical—*Dr. H. J. Orchard;* surgical—*Dr. T. J. O'Leary;* pediatrics—*Dr. H. A. Sincock;* obstetrics—*Dr. J. W. McGill;* eye, ear, nose and throat—*Dr. T. J. Doyle;* anesthesia—*Dr. F. G. Johnson, Jr.;* clinical laboratory—*Dr. V. E. Ekblad;* records—*Dr. D. R. Searle.*

Directors of the Hospital have elected the following new officers: president and chief of staff, *Dr. J. W. McGill;* vice-president, *Dr. V. E. Ekblad;* secretary–treasurer, *Dr. Conrad W. Giesen.*

At the annual banquet and business meeting at which officers were elected, *Dr. John Baird*, Superior, was honored with a birthday cake and gift on his eighty-second birthday.

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All eleven members of the Langlade County Medical Society have paid their 1942 dues. The complete remittance for these members was received on January 11, 1942.

MARRIAGES

Dr. James Nissenbaum, Appleton, and Miss Jean Hoffman, Ironwood, Mich., on January 4.

BIRTHS

A son to Dr. and Mrs. M. H. Wirig, Madison, January 17.

DEATHS

Dr. Leo J. Drozniakiewicz, Milwaukee, died suddenly of a heart attack at his home, on January 20, at the age of 60.

Dr. Drozniakiewicz was a native of Milwaukee, having attended the schools there. In 1907 he was graduated from Marquette University School of Medicine. He practiced medicine in Milwaukee for thirty-five years, serving as city physician for twenty-five years. He was also medical examiner for the Metropolitan Life Insurance Company.

Dr. Drozniakiewicz was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow; a son, Donald; his mother, Mrs. Cecelia Drozniakiewicz; two sisters, Victoria and Mrs. Phyllis Ciechorski; and two stepbrothers, Dr. Edwin and Alfred Drozniakiewicz.

Dr. John C. Hubenthal, Belmont, died at his home on January 18, at the age of 73.

Dr. Hubenthal had practiced medicine in Belmont for forty-five years. He was a life member of the Lafayette County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow, and a son, Homer.

Dr. Henry A. Pfeifer, Milwaukee, died in a Milwaukee hospital, on January 12, after a six months' illness. He was 59 years of age.

Dr. Pfeifer was born in Plymouth on December 23, 1883. He attended the public schools in Plymouth, and studied medicine at the Wisconsin College of Physicians and Surgeons, graduating in 1900. Later he pursued a course of graduate study at the University of Vienna in Austria. Before going to Vienna he practiced medicine for fourteen years at Jackson, but after his return from Europe

he established his practice at Milwaukee which he maintained until his death.

Dr. Pfeifer was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow; a son, William; three daughters, Mrs. Ruth Dahlberg of Galesburg, Illinois; Mrs. Helen Bolln of Shorewood, and Mrs. Katherine Black of Arlington, Virginia; his mother, Mrs. Charles Pfeifer of Plymouth; a brother, Dr. F. J. Pfeifer of New London; two sisters, Mrs. Vera Gardner of Plymouth and Mrs. Fulda Nimz of Manitowoc; and two grandchildren.

Dr. Francis A. Thompson, Milwaukee, died suddenly of a heart attack at a Milwaukee hospital on January 8. He was 68 years of age.

Dr. Thompson was born in 1873. He studied medicine at the Wisconsin College of Physicians and Surgeons and was graduated in 1897. After graduation he began the practice of medicine in Milwaukee, which was continuous until his death with the exception of a year's interval during World War I. He held the rank of Lieutenant Colonel in the United States Army, and at the time of World War I he was overseas for a year with Base Hospital 22, which was stationed in France.

Dr. Thompson was a member of the Milwaukee preceptorial staff of the University of Wisconsin, and a member of the staff of the Marquette University School of Medicine as assistant clinical professor of medicine. He held membership in the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, the American Medical Association, and the Milwaukee Academy of Medicine.

Surviving him are his widow, and a brother, Arthur, of Wauwatosa.

CORRESPONDENCE

Co-operative Extension Work in Agriculture and Home Economics

State of Wisconsin

Madison, Wis., January 20, 1942

Mr. C. H. Crownhart
State Medical Society of Wisconsin
Madison, Wisconsin
Dear Mr. Crownhart:

I appreciated very greatly your courtesy in sending me copies of the Medical Journal containing the article on butter. I shall see that a copy is promptly placed in the hands of Mr. Christensen and Mr. Elvehjem.

We are planning to use 3,000 reprints of the article and know that we can make very good use of this timely material.

Thanking you for your many courtesies, I am

Sincerely yours

Andrew W. Hopkins
Extension Editor

SOCIETY RECORDS

New Members

J. P. Sprague, Minocqua.

Lieutenant J. T. Murphy, 803 North Broadway, Green Bay.

Lieutenant R. K. (j.g.) Peterson, U. S. Naval Hospital, Washington, D. C.

P. S. Emrich, Oshkosh National Bank Building, Oshkosh.

G. J. Bachhuber, Athens.

J. F. Maser, Milltown.

R. J. Groves, Lodi.

R. W. Beck, Mendota State Hospital, Mendota.

R. V. Kuhn, 107 North First Street, Watertown.

K. W. Covell, 435 Baker Block, Racine.

Lenore Patrick, Rutledge Charity Building, Chippewa Falls.

H. R. Hunter, Northern Wisconsin Colony and Training School, Chippewa Falls.

Changes in Address

L. O. Holmes, Oshkosh, to Irving Zuelke Building, Appleton.

Lieutenant M. M. Guzzetta, Fort Sam Houston, Tex., to Det. 4th Medical Supply Depot, A. P. O. 810, % Postmaster, New York, N. Y.

K. J. Denys, Wrightstown, to 705 Bellin Building, Green Bay.

W. H. Remer, Chaseburg, to 424 South Eleventh Street, La Crosse.

J. R. Richter, Waunakee, to Chaseburg.

Lieutenant J. P. Malec, Camp Forrest, Tenn., to Chanute Field, Ill.

Lieutenant A. F. Rogers, Carlisle, Pa., to Fort McClellan, Ala.

R. J. Dalton, Fifield, to Box M M, Cristobal, Canal Zone

Captain S. A. Montgomery, Fort Sam Houston, Tex., to Camp Bowie, Tex.

P. E. Wright, Wisconsin Rapids, to 9 South Eighth Street, Manitowoc.

Lieutenant Colonel G. J. Hathaway, Camp Livingston, La., to Third Army Headquarters, San Antonio, Tex.

E. K. Steinkopff, Milwaukee, to Division of Tuberculosis Control, Springfield, Ill.

Lieutenant M. O. Boudry, Waupaca, to Naval Training Station, Great Lakes, Ill.

Lieutenant B. I. Brindley, Madison, to Naval Training Station, Great Lakes, Ill.

Lieutenant Edward McCormack, Camp Forrest, Tenn., to Lawson General Hospital, Ward A-2, Atlanta, Ga.

S. S. Houkom, Green Bay, to Duluth Clinic, Duluth, Minn.

Captain J. M. Sullivan, Fort Sam Houston, Tex., to Station Hospital, Camp Berkeley, Tex.

THE PRESS

And So It Goes*

By RICHARD S. DAVIS

How to Remain Well and Strong

HERE is something that should have been presented much sooner, but most of the state's population is still alive, despite the delay, and in a position to benefit from the counsel now offered. It is excellent advice because it comes from the state medical society and it doesn't cost you a cent. When was there a greater bargain?

The theme of all sagacious men in 1942 is certain to be conservation—saving of rubber, metal, string, paper, papa's pants and mama's girdle stays. The wastrel in this year of our Lord is bound to be looked upon with scorn and derision, whether he is profligate with matches or toothpicks. The all-American hero of the season is not likely to be the most niggardly among us, but we'll all be tipping our hats to the prudent and you can lay a good bet on that.

In line with this conservative trend, the state medical society has given thought to what may be done about making the most of the common health. The boys have put their heads together and evolved this declaration:

Your health depends to a large extent on the time and care you give to planning your daily life, so that your body will be protected from disease, and made strong and vital, through observance of simple health rules. The following New Year's resolutions are suggested to help you start the year right:

No. 1. I will not eat too much, nor will I exercise too little during the year. I will eat a variety of foods, in order that my body may be adequately nourished. I will not forget the importance of eating fresh fruits and vegetables.

No. 2. I will work during working hours and play when I play. I will seek to avoid late hours and I will not neglect to take my annual vacation.

No. 3. I will learn all I can about the care and preservation of my health from reliable sources and will strive to apply the knowledge I gain faithfully and conscientiously.

No. 4. I will go to my physician for an annual health examination in order that he may help me to keep well.

No. 5. I will have my children immunized against diphtheria and with them I will be vaccinated against smallpox and typhoid fever, if these precautions have not been taken already.

No. 6. I will consider the health and welfare of others.

Now there, if the lesson is taken to heart, are precepts enough to see anyone through the winter at least. However, it is the custom in this corner to serve advice in clusters of 10, like radishes or little green onions. Consequently four rules have been added, but you are cautioned to remember that the additions are a layman's who occasionally, but not often, has been wrong. Now then:

No. 7. I will not quarrel with anybody about who has put in his ante and who hasn't, nor where the lead is, nor who is the better football player, Pat Harder or Bill Daley.

No. 8. I will not shovel the sidewalk when I feel the least bit faint.

No. 9. I will not say what I think—not loudly, that is—about the congressional races in the fourth and fifth districts.

No. 10. Whenever I can't beg, borrow or steal a ride, I will walk. And breathe deeply. And try not to say, "Aw, nuts!"

* Reprinted from *The Milwaukee Journal*, January 8, 1942.

PRIZE AWARD CONTEST AMERICAN ASSOCIATION OF OBSTETRICIANS, GYNECOLOGISTS AND ABDOMINAL SURGEONS FOUNDATION, INC.

Eligible contestants for "The Foundation Prize" of $150 include interns, residents, graduate students in obstetrics, gynecology or abdominal surgery, and physicians with an M. D. degree who are actively practicing or teaching obstetrics, gynecology or abdominal surgery. For the rules of the contest and other information, write Dr. J. R. Bloss, secretary, American Association of Obstetricians, Gynecologists and Abdominal Surgeons Foundation, Inc., 418 Eleventh Street, Huntington, West Virginia.

Coming Events

STATE MEDICAL SOCIETY

Spring clinics—April 27, 28 and 29 (see page 154).
Annual meeting—September 14, 15 and 16 (see page 152).

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University of Wisconsin Medical School Schedule of Saturday Morning Clinics

Feb. 21. Obstetrics and Gynecology: Carcinoma of the Uterus—Prophylaxis, Diagnosis and Treatment. Dr. Campbell and Associates

Feb. 28. Medicine: Sigmoidoscopic and Radiologic Correlation in Diagnosis and Treatment of Colonic Disorders. Dr. Puestow and Associates

Mar. 7. Orthopedics: Backache. Dr. Burns and Associates

Mar. 14. Otolaryngology: Treatment of Common Disorders of the Respiratory Tract. Dr. W. M. Nesbit and Associates

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American Association of Industrial Physicians and Surgeons; American Industrial Hygiene Association

The American Association of Industrial Physicians and Surgeons and the American Industrial Hygiene Association will hold their joint annual convention in Cincinnati from April 13 to 17, 1942. A program is in preparation in which important medical and hygienic problems associated with the present huge task of American industry will be presented and discussed in clinics, lectures, symposia, and scientific exhibits. The central purpose of the meeting will be to provide a five-day institute for the interchange and dissemination of information on new problems as well as for the consideration of up-to-date methods of dealing with those that are well known. The industrial physicians have taken responsibility for the program of the first two and a half days and the hygienists for the remainder of the five days, but most of the subjects chosen for discussion will be of interest not only to physicians, but equally so to industrial engineers, and executives.

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Chicago Selected For 1942 Clinical Congress of the American College of Surgeons

Because of the war, the thirty-second annual Clinical Congress of the American College of Surgeons will be held in Chicago, October 19 to 23, instead of in Los Angeles as originally planned. Headquarters will be at the Stevens Hotel. The twenty-fifth annual Hospital Standardization Conference sponsored by the College will be held simultaneously. The programs of both meetings will be based chiefly on wartime activities as they affect surgeons and hospital personnel in military and civilian service.

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Milwaukee Children's Hospital—Schedule of Clinical Presentations

The staff of the Milwaukee Children's Hospital has arranged a schedule of clinical presentations for the coming months. A tentative partial program follows. The time of the clinical presentations will be from 12:30 to 1:30 p.m. Dr. Arthur A. Schaefer will direct the surgical clinics, Dr. Walter P. Blount the fracture service clinics, and Dr. A. L. Kastner the pediatric clinics.

FEBRUARY

Surgical Clinic, Monday, February 16
Presentation of Cases. Discussion of Appendicitis and Complications

Pediatric Clinic, Tuesday, February 17
Riboflavin Metabolism. Discussion by L. E. Booher, Ph. D., Milwaukee

Pediatric Clinic, Friday, February 20
Epidemic Pharyngitis. Discussion by S. E. Kohn, M. D., Milwaukee

Surgical Clinic, Monday, February 23
Presentation of Cases. Discussion of Mesenteric Lymphadenitis

Fracture Service Clinic, Tuesday, February 24
Out-Patient Clinic

Pediatric Clinic, Friday, February 27
Developing a Personality in Children. Discussion by S. G. Geiger, M. D., Milwaukee

MARCH

Surgical Clinic, Monday, March 2
Presentation of Cases. Discussion of Septicemia

Fracture Service Clinic, Tuesday, March 3
Out-Patient Clinic

Pediatric Clinic, Friday, March 6
Nicotinic Acid Metabolism. Discussion by L. E. Booher, Ph. D., Milwaukee

Surgical Clinic, Monday, March 9
Presentation of Cases. Lung Abscess. Discussion by John Steele, M. D., Milwaukee

Fracture Service Clinic, Tuesday, March 10
Out-Patient Clinic

Pediatric Clinic, Friday, March 13
Diabetes. Discussion by G. F. Kelly, M. D., Milwaukee

Surgical Clinic, Monday, March 16
Presentation of Cases. Discussion of Pericarditis —Suppurative and Adhesive

Program For One Hundred First Annual Meeting Nears Completion

E. R. SCHMIDT, M. D.

MONTHS ahead of schedule Dr. E. R. Schmidt, Madison, has completed the scientific program for the One Hundred First Anniversary Meeting of the State Medical Society of Wisconsin. The program virtually in final form was reviewed by the Council on Scientific Work on Sunday, January 25. The dates for the meeting to be held in the Milwaukee Auditorium are Monday, Tuesday and Wednesday, September 14, 15 and 16.

Sectional Meetings

Assisting Dr. Schmidt and the Council on Scientific Work are nine sectional program chairmen. They are as follows:

Obstetrics and Gynecology
Dr. Francis M. Frechette, Janesville

Surgery
Dr. Albert R. Tormey, Madison

Medicine
Dr. Gjermund Hoyme, Eau Claire

Ophthalmology and Otolaryngology
Dr. Reinhold O. Ebert, Oshkosh

Pediatrics
Dr. Francis R. Janney, Wauwatosa

Urology
Dr. Alf H. Gundersen, La Crosse

Cardiology
Dr. Chester M. Kurtz, Milwaukee

Orthopedics
Dr. Chester C. Schneider, Milwaukee
Dr. Walter P. Blount, Milwaukee

Round-Table Luncheons

The round-table luncheons which have proved to be such a popular feature of the Wisconsin meetings have been increased in number by the Council on Scientific Work to accommodate more registrants than ever before. This also offers an opportunity to present a diversity of subjects. A studied effort has been made by Dr. Schmidt to include subjects of broad, general interest, as well as subjects of special interest to those who are devoting their time to one of the several specialties.

Motion Pictures

A new feature will be inaugurated by the Council on Scientific Work this year by reserving the first hour of each morning's scientific program for the showing of an outstanding scientific motion picture. The last hour of each day's program will likewise be set aside for motion pictures.

The Council on Scientific Work selected Dr. H. K. Tenney, Madison, to perfect this feature of the program. Among the motion picture subjects which have been arranged tentatively by Dr. Tenney are "Appendicitis in Childhood," "Skin Grafts," and "The Anatomy and Diseases of the Ear Drum." This last film has received high commendation by physicians in general practice who have had an opportunity to see it, as it presents information and details of the technique of a paracentesis of the ear drum, a procedure that confronts the physician in general practice, the pediatrician, the eye, ear, nose and throat specialist, and others.

Scientific Exhibits

The scientific exhibits at the One Hundred First Anniversary Meeting will be arranged and supervised by Dr. C. J. Smiles of Ashland. An increased number of exhibit booths has been set aside in the main arena. Dr. Smiles has reserved certain exhibits and his continued efforts are securing others that are particularly meritorious and of interest to physicians. Tentative reservations have been made for exhibits which are now being prepared under the direction of a special committee of the American Medical Association.

Also to be included in this year's meeting is a series of exhibits displaying physicians' hobbies. A complete description of this feature follows.

Meeting Days Changed

Note on your calendar now the dates of the One Hundred First Anniversary Meeting of the Society,—September 14, 15 and 16. The attention of the members of the Society is called to the fact that the meeting days have been changed from the customary Wednesday, Thursday and Friday to those of Monday, Tuesday and Wednesday. It was the joint opinion of the Council of the Society and the Council on Scientific Work that this change would be advantageous to members of the Society in that attending the annual meeting would necessitate fewer days of absence from the office.

The initial meeting of the House of Delegates is scheduled for Sunday, followed by shorter meetings on Monday and Tuesday. This will permit members of the delegate body to attend more of the scientific sessions than has been possible in recent years.

Outstanding Waterfowl Photographs, Guns, and Bells Will Be Displayed in Physicians' Hobby Show

ONE of the country's finest collections of waterfowl photographs will be displayed at the Physicians' Hobby Show to be held at the time of the One Hundred First Anniversary meeting of the Society on September 14, 15 and 16. Learning of Dr. Howard J. Lee's collection of waterfowl photographs, Dr. C. J. Smiles of Ashland, director of both the scientific exhibits and the Physicians' Hobby Show, secured assurance from Dr. Lee that he would display these pictures in the hobby show. *The Milwaukee Journal,* in commenting upon Dr. Lee's collection of waterfowl pictures, stated, "Many of Dr. Lee's prints have been acclaimed the best of their kind, representing a thorough understanding of the camera technique combined with a feeling of composition. The technique of the photographer is quite like that of the duck hunter. Blinds or decoys are set out. However, the blinds must be more perfect than the hunter's because the photographer attempts to get closer to the birds than is necessary for a hunter."

Guns

Another outstanding hobby collection which will be shown at the meeting is that of Dr. Paul F. Doege of Marshfield, who will display an unusual collection of exceedingly rare and valuable guns. Over 100 revolvers will be shown, as well as a representative group of rifles. Some of the firearms contained in the display were used as long ago as 500 or 600 years. In Dr. Doege's collection are revolvers used by the Pilgrims, soldiers in the Revolutionary, Civil, Spanish–American, World War I and the present war. The firing mechanisms of guns contained in the exhibit begin with the early matchlock, and are followed in order by the roselock, the flintlock, the pill lock, the percussion cap lock and finally the modern cartridge type. This excellent collection will be seen in the main arena of the Auditorium at the time of the meeting.

Bells

Dr. R. G. Arveson of Frederic will present an exhibit of a variety of bells gathered from various areas in the United States and from foreign countries. Some of these bells are representative of the Oriental countries, Swiss, Norwegian, Swedish, Russian and Early American. Bells from the size of a pencil eraser to that of the large farm dinner bell will be shown. Many styles, shapes and tones will be included in the collection.

Dr. Smiles reports that there has been an active interest in the hobby show and that space is being set aside for additional hobby exhibits as more collections are made known to him.

Your Application Blank is on Page 163.

Annual Postgraduate Spring Clinics

CHIPPEWA FALLS—APRIL 27
WAUSAU—APRIL 28
FOND DU LAC—APRIL 29

G. W. KRAHN, M. D.

CIRCLE on your calendar the dates of April 27, 28 and 29 as reserved for your attendance at the Fourth Annual Postgraduate Spring Clinics of the State Medical Society. The Council on Scientific Work, through Dr. G. W. Krahn who is in charge of arrangements, announces that physicians in the locality of Chippewa Falls, Wausau, and Fond du Lac will have an opportunity to attend a one-day clinical meeting offering practical scientific information that can be applied immediately in their individual practices.

Subjects

Dr. S. E. Gavin, Fond du Lac, chairman of the Council, will serve as general chairman at the clinics. Among the subjects to be presented are "Postpartum Perineal Repair," "Medical Management of Ulcers," "Surgery of the Gallbladder," "Differential Diagnosis in Drug Poisoning," and several other topics of interest in the day-by-day practice of medicine.

Round-Table Dinners

Round-table dinners will be held every day from 6 to 9 p.m. on the following subjects: surgery, general medicine, obstetrics and pediatrics, newer drugs, and industrial surgery. Each dinner will be held in a separate room, with a limited number of reservations accepted in order to stimulate free discussion. In previous years scientific papers were presented in the evening, but because of popular demand the Council on Scientific Work has dispensed with the evening papers and allotted increased time to the round-table dinners.

Manikin Demonstrations

A popular feature of the 1941 spring clinics,—the manikin demonstrations by Dr. W. C. Keettel,—will be repeated. Dr. Keettel, the special instructor in obstetrics and gynecology of the Bureau of Maternal and Child Health of the State Board of Health, will be available again for individual conferences with physicians. These conferences are for physicians only, without presentation of cases. Manikin demonstrations of normal as well as more complicated obstetrical deliveries will be given by Dr. Keettel.

Program

The tentative program announced by the Council on Scientific Work follows:

Monday, April 27—Chippewa Falls
Tuesday, April 28—Wausau
Wednesday, April 29—Fond du Lac

S. E. GAVIN, M. D., General Chairman

9:30 The Female Pelvis
9:40 Postpartum Perineal Repair
10:00 Some Phases of Gastro-Intestinal Diseases
10:30 Recess
Obstetrical Manikin Demonstration
10:45 Surgery of the Gallbladder
11:15 Pediatric Subject
11:45 Newer Drug Therapy
Luncheon
2:00 Industrial Surgery
2:30 Medical Management of Ulcers
3:00 Recess
Obstetrical Manikin Demonstration
3:15 Anatomy of Stomach and Gallbladder
3:25 Surgical Management of Ulcers
3:45 Differential Diagnosis of Drug Poisoning
4:15 Induction of Labor
4:45 The Physician in Wartime
6:00 Round-table Dinners
Obstetrics and Pediatrics
Newer Drugs
Surgery
General Medicine
Industrial Surgery

Minutes of the Council; Milwaukee, January 10, 1942

1. Call to Order

The Council convened at 9:00 a. m., Saturday, January 10, 1942, in the library of the University Club of Milwaukee.

2. Roll Call

The following were present, constituting a quorum: Councilors Gavin, Bowen, Pechous, Clark, Pippin, Heidner, Jegi, Krahn, Christofferson, Arveson, Johnson, Gramling, Fitzgerald, Blumenthal and Lambert; President Gundersen, Speaker Kurten, Treasurer Sisk, Vice-Speaker Fidler; Dr. J. C. Sargent, delegate to the American Medical Association; Dr. C. A. Dawson, chairman, Committee on Public Policy; Past-president R. P. Sproule, Milwaukee; Mr. C. H. Crownhart, secretary, Mr. G. B. Larson, assistant secretary; and Mr. James O. Kelley, executive secretary, The Medical Society of Milwaukee County.

3. Approval of Minutes of September, 1941, Meeting

Upon motion by Christofferson–Krahn, the minutes of the September meeting of the Council, as published in the November issue of *The Wisconsin Medical Journal*, were approved.

4. Election of a Chairman of the Council for 1942

Upon motion by Christofferson–Jegi (the assistant secretary presiding), Dr. S. E. Gavin, Fond du Lac, was nominated to succeed himself as chairman of the Council for the year 1942. Upon motion by Fitzgerald–Johnson, nominations were closed and the assistant secretary was instructed to cast the unanimous ballot of the Council for Dr. Gavin; the ballot was so cast.

5. Election of a Secretary of the Society and of the Council for 1942

Upon motion by Clark–Arveson, Mr. C. H. Crownhart was nominated as secretary of the Society and of the Council for the year 1942. Upon motion by Councilor Gramling, variously seconded, nominations were closed and the chairman was instructed to cast a unanimous ballot for Mr. Crownhart.

6. Election of a Treasurer of the Society and of the Council for 1942

Upon motion by Krahn–Bowen, Dr. Ira R. Sisk, Madison, was nominated to succeed himself as treasurer of the Society and of the Council for 1942. There being no further nominations, the secretary was instructed to cast a unanimous ballot for Dr. Sisk, and the ballot was so recorded.

7. Report of the Committee on Health and Public Instruction

The report of the Committee on Health and Public Instruction was previously submitted to the Council in mimeographed form. In substance, the committee recommended that it be authorized to prepare and arrange for the showing of several health exhibits at county fairs and at the Wisconsin State Fair, each exhibit containing some form of practical demonstration that would be of interest and value in the health educational program. It was the committee's belief that the cost of preparing and presenting these booths, including shipping and other items of expense, would be approximately $325.

The matter was discussed by Councilors Gavin, Johnson, Jegi, Krahn, Pechous, Fitzgerald, Bowen, Gramling, Christofferson, Arveson, Clark and Heidner. Upon motion by Krahn–Jegi, the matter of exhibiting at county fairs and the state fair was left at the discretion of the committee, with the provision that such exhibits be presented with the cooperation and at the initiation of the individual local county medical societies, and that the appropriation suggested be approved for use, if necessary. Carried unanimously.

8. Farm Security Administration

Chairman Gavin announced that through Councilor Pippin representatives of the Farm Security Administration had requested a hearing. These guests, who were introduced by Councilor Pippin, were Dr. R. F. Boyd, medical director for the Farm Security Administration in Wisconsin; Mr. A. A. Puhlmann, Washington, D. C., and Mr. J. F. Machotka, Madison.

These representatives stated that the councilors had been approached individually with reference to the Farm Security Administration prepaid medical care plans, and amplified previous discussion with a view to securing approval of the State Medical Society of Wisconsin for trial plans in various counties of the state. There was discussion, while the guests were in attendance, and after their departure, by Councilors Krahn, Heidner, Johnson, Christofferson, Bowen, Clark, Gavin, Fitzgerald, Jegi and Gramling.

Following discussion by Assistant Secretary Larson, and upon motion by Christofferson–Arveson, the Council unanimously voted to refer the proposal of the Farm Security Administration to the Committee on Voluntary Sickness Insurance for study and recommendation.

9. Report of Committee on Safety on Public Highways

The report of the Committee on Safety on Public Highways was presented to the Council in mimeographed form prior to the meeting. It recommended establishment of a subcommittee composed of members of the Society specializing in the field of toxicology and research, to study the scientific status and legal aspects of chemical tests for alcoholism and to report to the committee its recommendations in the field of legislation.

The committee further recommended an examination of the problems of drivers' licensure which concern the scientific aspects of medicine, and specifically, that a one-day safety conference be held in Wisconsin, to which would be invited representatives of the county medical societies and interested public officials. The estimated cost of this program was $1,300.

The mimeographed report was amplified by Secretary Crownhart and was discussed in detail by Councilors Blumenthal, Krahn, Heidner, Fitzgerald, Gramling and Clark. Upon motion by Clark–Christofferson, carried unanimously, the Committee on Safety on Public Highways was authorized to continue its studies in the field of chemical tests for alcoholism and medical problems associated with drivers' licensure. Approval for the one-day safety conference was withheld.

10. Report of the Treasurer

Dr. Ira R. Sisk, treasurer, presented his report for the calendar year 1941, as follows:

STATE MEDICAL SOCIETY OF WISCONSIN
REPORT OF DR. IRA R. SISK, TREASURER
For the Year Ended December 31, 1941

Pursuant to authorization given by the House of Delegates in 1941, all distinction between the general fund and the medical defense fund has been abolished, and the two now stand combined as the general fund of the Society.

General Fund

Cash on hand, January 1, 1941			$ 8,550.19
Receipts			
Membership dues		$37,059.40	
Special assessments		24,457.57	
Annual meeting revenues		8,211.50	
Graduate center fees		2,177.00	
Women's Field Army—appropriation for graduate centers		200.00	
Monthly installments on insurance policy proceeds		693.21	
Miscellaneous receipts (refunds of expense)		317.69	
Sale of printed materials, equipment, etc.		188.36	
Interest on investments		715.00	
Share of social security taxes, *Wisconsin Medical Journal*		21.48	
Total receipts			74,041.21
Total to be accounted for			$82,591.40
Disbursements			
Constitutional Officers and Committees			
President's travel	$ 500.00		
Council and committees	2,734.43		
Books and periodicals	333.46		
Delegates to the A. M. A.	255.60		
Auxiliary	100.00		
Secretary's salary	7,070.00		
Secretary's travel expense	669.43		
Group total		$11,662.92	
Staff			
Salaries of staff	$10,072.78		
Assistant secretary's normal travel	429.63		
Group total		10,502.41	
Administrative Expenses			
Accounting and insurance	$ 783.34		
Social security taxes	333.83		
Insurance on secretary	244.50		
Rent	1,800.00		
Telephone and telegraph	$871.14		
Supplies and electric light	838.74		
Postage and printing	2,165.41		
Fixtures and upkeep	651.12		
Miscellaneous	1,009.50		
Group total		$8,697.58	
Membership, Special Services			
Legal	$ 3,172.07		
Special bulletins to members	124.19		
Blue Book issue	600.00		
Annual meeting	12,354.05		
Graduate centers	2,818.58		
Wisconsin Medical Journal	1,800.00		
Industrial health	5,463.63		
Group total		26,332.52	
Public Health, Special Services			
Hygeia	$ 291.71		
Press	423.40		
Lay publications	1,392.38		
Bulletins to members	965.21		
Special reports in *The Journal*	463.41		
Telephone and telegraph	438.11		
Services — general counsel	1,772.68		
Voluntary sickness insurance trials	650.92		
Group total		$ 6,397.82	
Total budgetary disbursements		$63,593.25	
Non-Budgetary Disbursements			
Investment securities purchased		$ 8,225.16	
Dues and assessments refunded		678.50	
Medical defense disbursements		404.00	
Total disbursements			$72,900.91
Cash on hand, December 31, 1941			$ 9,690.49

Securities Owned December 31, 1941

	Interest Rate	Maturity	Face Value
Dominion of Canada	2½	8–15–45	$ 2,000.00
Dominion of Canada	3¼	1–15–61	2,000.00
Pacific Telephone and Telegraph Company	3¼	12– 1–66	2,000.00
Milwaukee Gas Light Company	4½	3– 1–67	2,000.00
Canadian National Railway Company	5	10– 1–69	2,000.00
Dayton Power and Light Company	3	1– 1–70	3,000.00
Wisconsin Power and Light Company	3¼	8– 1–71	3,000.00
United States Treasury bonds	3¼	4–15–46	2,000.00
United States Treasury bonds	2½	9–15–72	3,000.00
United States Savings bonds—Defense Series G, 1941	2½	6– 1–53	2,000.00
Pennsylvania Power and Light Company	3½	8– 1–69	2,000.00
Southern California Edison Company, Ltd.	3	9– 1–65	2,000.00
Wisconsin Gas and Electric Company	3½	4– 1–66	1,000.00
Milwaukee County, Wisconsin, Metropolitan Sewerage bond of 1925	4½	3–18–44	1,000.00
Securities owned, December 31, 1941			$29,000.00

Summary of Society's Funds December 31, 1941

Cash on deposit	
Treasurer's account at the First National Bank, Madison	$ 9,690.49
Secretary's petty cash account at the American Exchange Bank, Madison	300.00
Secretary's dues account at the American Exchange Bank, Madison ($1,450—Advance Dues for 1942)	1,550.00
Securities owned—face value	29,000.00
Proceeds of insurance policy on deposit with the Aetna Life Insurance Company	9,457.60
Total, Society funds, December 31, 1941	$49,998.09

There was discussion by the councilors, and upon motion by Christofferson–Blumenthal, the report of the treasurer was accepted. Chairman Gavin commended the treasurer upon the financial status of the Society, based upon his report.

11. Report of the Secretary's Office

Secretary Crownhart supplemented the interim report, as presented to the Council in mimeographed form prior to the meeting:

INTERIM REPORT OF THE SECRETARY'S OFFICE

Membership

As of December 31, 1941, our membership totalled 2,579, compared with a total membership of 2,550 for one year previous. For the information of the Council, membership is summarized as follows:

1. Fully paid members	2,410
2. Partially paid members	12
3. Members in military service who have paid no dues in 1941	38
4. Members in military service who paid pro-rata dues in 1941	57
5. Members in military service who have not reported date of induction	21
6. Life members, honorary members, members whose dues were waived because of temporary but serious incapacity	62

The Society has fifty-seven delinquents, but some of these are in military service or have removed from the state. A very comprehensive effort has been made,—perhaps more so than in previous years,—to keep this figure to a minimum. It may be that during the course of 1942, some of these members will make up their delinquencies in order to regain their membership status.

Membership in 1942

As of December 31, there are 116 members of the Society in military service, or approximately 4.4 per cent of the total. A study of the membership records in the comparable period of 1917–1918 shows that 25 per cent of the physicians of Wisconsin were in military service. What we may expect in 1942 and ensuing years is uncertain. It must be anticipated that no smaller percentage will be taken into service during the present war. In view of the rapid expansion of army, naval and air services, it may be that a considerably larger percentage will be required. Certain it is that all government services have been greatly expanded in the last twenty-five years, and we may find that many available physicians are in non-military services of the government in various defense efforts.

The comment is offered that in view of this situation, the Council may wish to view the organization of the Society as being capable of moving in various directions as the need becomes apparent, without being committed to programs the importance of which may be entirely modified by developments during the course of the ensuing year. Activities of the Society must, more than ever, be wholly dependent upon membership need. As a large proportion of the physicians of Wisconsin are called into service, certain activities of the Society may become of increasing importance, with others possessing less relative value.

County Secretaries

In reporting to the Council a year ago, your secretary said, "Early in the year a booklet of mimeographed instructions for the county secretaries was sent from the central office. This was welcomed as answering many questions as to procedure that repeatedly arise in the conduct of a county society's affairs.

"Your secretary is deeply impressed by the amount of effort expended by the county secretaries in performing with the necessary exactness the duties of their office. No more important office in the structure of our Society is to be found than that of the county secretary. With the exception of the large society in Milwaukee County, all county secretaries are physicians who serve without compensation. A grateful acknowledgment is made of their key service within their respective societies and to your State Society that very literally could not live and make its accomplishments without these men who give so much of themselves."

The personnel of your present office is impelled to say that the cooperation of the county society secretaries in the complications that inevitably arose following the death of George Crownhart, has been of signal assistance in the administration of this portion of your Society's work. The work of the office of the county society secretaries is becoming increasingly burdensome to its incumbents, and the detailed work that has arisen in 1941 and which will increase in 1942, with respect to induction of members, their constant changing of address due to military and civilian needs, will impose an even greater responsibility. The councilors are urged to convey to the county society secretaries in their respective districts, the appreciation of the Council and of the secretary's office for the time they have so generously given, and the need of these efforts being continued with ever increasing vigor in 1942.

The Wisconsin Medical Journal

The preliminary statement for *The Wisconsin Medical Journal* for the current year of operation is given at the end of this report. That its high quality has been maintained during the last six months is due in large measure to the untiring assistance of Miss Lucia Stolp who has devoted, during that period, practically her entire time to this work. A full-time employe, under the direction of Miss Stolp, has recently been added to fill the vacancy caused by the resignation of Miss Cridland. It is hoped that her work with *The Journal* will become of such character as to enable Miss Stolp to return more and more of her time to the administration of the Society's office routine.

The current Blue Book issue of *The Wisconsin Medical Journal* was increased in size and had, as an added feature, an article prepared under the direction of the State Board of Medical Examiners dealing with the subjects of licensure laws in the State of Wisconsin and restrictions on cult treatment of the sick.

The Blue Book issue is unique to Wisconsin and has received a considerable amount of favorable comment. We are advised that in surveying tax returns of physicians, the income tax article in *The Journal* is used as a model by both state and federal officials in Wisconsin. Reprints of the article on poor relief are distributed widely throughout the state, the Department of Public Assistance receiving between 300 and 400 of these reprints.

WISCONSIN MEDICAL JOURNAL
Madison, Wisconsin

TENTATIVE INCOME AND PROFIT AND LOSS STATEMENT
For the Year Ended December 31, 1941

Income	
Advertising*	$ 9,810.82
Subscriptions	109.00
Total publication income	$ 9,919.82

Expenses		
Printing	$8,353.11	
Salaries**	1,088.32	
Cuts	459.88	
Mailing	570.63	
Rent	540.00	
Accounting service	180.00	
Editorial expense	124.75	
Miscellaneous expense	25.25	
Supplies	13.45	
Discounts allowed	18.40	
Depreciation	12.42	
Old age benefit tax	10.89	
Total publication expenses		11,397.10
Publication (loss)		($1,477.28)
Less: State Medical Society appropriation		1,800.00
Net income for the year		$ 322.72

Balance Sheet December 31, 1941

Assets		
American Exchange Bank		$ 1,328.13
Accounts receivable—advertisers*		943.17
Mailing envelopes inventory		57.10
Postage deposit		100.34
Copyright deposit		24.00
Office equipment (depreciated value)		77.01
Total assets		$ 2,529.75
Liabilities and Surplus		
Current liabilities		None
Surplus, January 1, 1941	$2,207.03	
Add: Net income for the year (as above)	322.72	
Surplus, December 31, 1941		2,529.75
Total liabilities and surplus		$ 2,529.75

* Subject to correction when final figures are available.

** The salary item normally totals $1,800, being less for 1941 due to resignation of Miss Cridland, the vacancy thus created existing for several months. The present salary charges total $115 monthly, but will be subject to increases during 1942 until the former total is reached.

The Year 1941

The year 1941 created exceptional problems for the State Medical Society of Wisconsin. It was a legislative year, which increased the burdens of the Society far beyond its normal load; the Society lost its secretary at a time when his executive abilities were immediately needed in connection with the annual meeting of the centennial year, as well as in relation to problems of the profession generally; the one office member particularly skilled in the work of *The Wisconsin Medical Journal* resigned her position; the nation became involved in World War II. But the Society has carried on,—a tribute to the loyalty of the profession throughout Wisconsin, a tribute to George Crownhart and his organizing abilities.

Faced with the uncertainties of the immediate years ahead, the development of the financial program and general policies of the Society has been difficult. When the Council meets, a report of the treasurer will be available as of December 31, 1941. Your office reports at this time, however, that while certain budgetary items in the 1941 budget estimates proved insufficient, savings were effected in other respects so that the sum total of the budget for that year was not met. The 1941 budget appropriated $57,276 from current membership income, together with the receipts used as a revolving fund from such sources as the annual meeting and the graduate centers. Net expenditures, excluding membership refunds to those in service, will total approximately $52,400, leaving an unexpended balance of nearly $5,000 compared with $3,000 a year ago.

Councilors will recall that the proceeds of the life insurance policy of which the Society is beneficiary have been left with the insurer to be remitted over a ten-year period at an interest rate of approximately 3½ per cent. This will permit reinvestment of the proceeds so that the ultimate yield of the principal sum may be about 5½ per cent.

The Budget For 1942

Approval of the current budget is the prerogative of the Council each January. The tentative budget presented before the delegates at the preceding annual meeting is of an informative character, to provide full information basic to the establishment of dues.

Councilors will recall that the budget suggested last fall was accepted with but one minor change, and upon it dues for 1942 were determined at $25.

Since presentation of that budget to the House of Delegates, a new condition long anticipated now applies. The country is at war, and in that war physicians will participate to a greater extent than any other group. During 1917–1918, approximately 25 per cent of the members of the Society were called into service,—the question for 1942 becomes one of how long before that percentage will be reached in this war and how much it will be exceeded. That we cannot predict with any accuracy; one estimate is as good as another.

It seems prudent to assume that ultimately the percentage of our membership in service will exceed the 1917–1918 figures, reaching a maximum, perhaps, of 35 per cent. The best estimate we can make now is a total of perhaps 20 per cent by the end of 1942,—more thereafter. The budget suggested by your secretarial office follows in some detail. It is designed to be flexible. Under it your secretarial office is prepared to adjust Society's activities to a 20 per cent decrease in income from the membership and, if necessary, to a 30 per cent decrease this year. As the need becomes apparent, the adjustments would be made. This would not be easy, nor desirable, yet we must be prepared for these possibilities. No service essential to public welfare can be eliminated; all machinery and interest must be maintained to resume normal and perhaps even abnormal activity.

Your counsel suggests that while transition will be rapid, there will be an opportunity to forecast what is happening. The question is not so much what will happen, as it is *when* all this will come about. A program of emphasis and activity that may be adjusted readily is the only one that appears feasible. We must not be radical, nor hasty,—but certainly cautious and extremely careful.

The Society's Office

At the present time *The Wisconsin Medical Journal* has a full-time employe, Miss Hilma Severson, and is accountable also for a part of Miss Stolp's time. One of the Society's regular employes, Miss Ethel Wichern, has gone on half-time in an effort to advance her education at the University of Wisconsin. Mrs. Alberta Marquardt, a former employe of the Society, has come into the office full-time since the annual meeting, but only on a semi-permanent basis. Mrs. Helen Brandt Newby and Mr. Hayden Smith, continue in their respective capacities.

George Crownhart built an office objective that permeates the entire organization. He did not consider the State Medical Society of Wisconsin as an impersonal representative of a group of physicians. Rather, he conceived its office as being at the personal command of individual physicians throughout the State of Wisconsin. He never lost sight of a concept which was his creed of obligation to the membership.

(Continued on page 160)

The art of doing things well

EVERY empty capsule made by Eli Lilly and Company passes under the watchful eyes of a Lilly inspector. When bright light is transmitted through glistening gelatin, minute cracks and bubbles are detected — defects which would detract from the perfection of Lilly Pulvules (filled capsules). An expert inspects 200,000 capsules a day, and while less than one percent is discarded the operation is regarded as an essential safeguard to Lilly Quality.

Lilly

Eli Lilly and Company

PRINCIPAL OFFICES AND LABORATORIES, INDIANAPOLIS, INDIANA, U. S. A.

His eighteen years as secretary of the State Medical Society of Wisconsin and the concept of obligation he created are not readily forgotten by the members. From inquiries and correspondence that are directed continually to the secretarial office, it is clearly apparent that the Society is not something to which the physician belongs,—it *is his* Society. It is here to serve his professional and scientific interests, and he relies upon it constantly.

In the uncertain times that lie ahead, your secretarial staff pledges its utmost cooperation that George Crownhart's concept of duty and responsibility shall not be forgotten, and that the State Medical Society of Wisconsin shall continue to be outstanding in its efforts to serve the individual members of the profession and their scientific needs in the countless ways that are its privilege.

Respectfully submitted,
C. H. CROWNHART.

The report of the secretary's office was ordered filed.

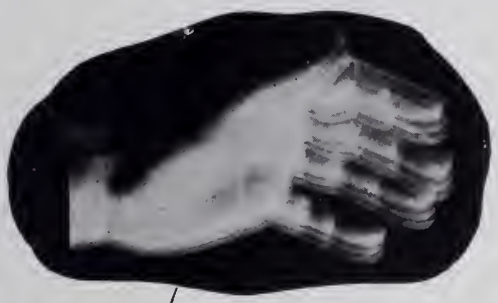
12. The 1942 Normal Budget

The recommended budget for 1942, with indicated adjustments in event of decreased income, was presented by Secretary Crownhart, item by item, with general discussion at many points. The Council accepted the principle of approving a normal budget, recognizing the possibility that adjustments might be necessitated through members being accepted into the armed services of the country. The adjustments suggested were referred to the Executive Committee of the Council to act upon as the occasion may demand, the Council simply approving a normal budget for a normal year. The action on the normal budget follows:

	Recommended 1942 Normal Budget $55,625
I. *Constitutional Officers and Committees*	
1. *President.*—Initially authorized by the House of Delegates in 1935, this has been an annual appropriation to the president to assist in travel, long distance telephone calls, and other expenses incident to the office. Undoubtedly responsibilities of the president will increase during the coming year but no adjustment is indicated in event of decreasing income	$500
2. *Council and committees.*—The activities of the Society have required four or five meetings of the Council each year, with its sixteen voting members and four ex officio members. While councilors are entitled to traveling expense, actually only those who travel some distance file statements. This appropriation also covers meetings of the various committees of the Society, $250 for stationery and postage expense of the councilors and committee members (such as annual meeting committee chairmen) who are called upon to do a considerable amount of correspondence. The normal budget provides for about half of all such expenses were they all billed. There will be a shifting of activities to different foci of importance during 1942, and although temporary savings may be effected through greater use of mail ballots, Executive Committee meetings and similar devices, it is the belief of your counsel that no decrease is indicated (except in event of dire necessity) in so important an activity of the Society	$2,500
3. *Books and periodicals.*—The appropriation for 1941, a legislative year, proved insufficient to provide councilors and committee members with all the publications found to be of important factual background. Yet, in the face of necessity, adjustments are possible though not desirable. $250 was appropriated in 1941	200
4. *Delegates to the American Medical Association.*—Wisconsin has three A. M. A. delegates. Formerly, a delegate was reimbursed for railway and pullman fare alone, having half of his time free to attend scientific sessions. The work of the A. M. A. delegate assembly has so increased as to keep it in substantially continuous session. The 1942 session will be held in Atlantic City, and the appropriation is sufficient to provide each delegate, in accordance with earlier established policy, with substantially full reimbursement for actual expenses	375
5. *Auxiliary.*—The Auxiliary receives but 25 cents from its members. Its importance in public health work warrants continuance of the limited amount of $100 to assist the four principal state officers in defraying their postage and stenographic expense	100
6. *Secretary, salary.*—The salary of the secretary has been $9,000. The amount suggested here is that used before the House of Delegates in determining dues	6,000
7. *Secretary, travel.*—The secretary has been reimbursed, within the budget appropriation for that purpose, for actual expense necessitated by official travel. Committee meetings outside of Madison, the A. M. A. sessions and conferences, and similar functions are necessarily attended. The normal budget for 1941 provided $1,200; it is anticipated that lowered income by the Society perhaps will indicate the very conditions that should require an even larger amount of travel, but this probably can be accomplished through careful selection of trips	1,000
Total—Constitutional officers and committees (1941 total $13,925)	$10,675
II. *Staff*—The general office staff was reduced one-third in 1940. Note specific appropriations for comment.	

(Continued on page 162)

IN POST-ENCEPHALITIC PARKINSONISM



In post-encephalitic parkinsonism, Benzedrine Sulfate Tablets will often produce marked symptomatic improvement—especially when administered in conjunction with the usual doses of hyoscine, stramonium or atropine.

With this combined therapy, drowsiness, muscular rigidity and tremor, lowered mood, salivation and oculogyric crises can often be controlled or eliminated.

NORMAL DOSAGE: 20 to 40 mg. daily. One-half of the dose at breakfast and the other half at noon. In exceptional cases, larger doses may be necessary.

Benzedrine Sulfate should be used with caution in hypertensive cases and should not be used in coronary disease and other cardiac conditions in which vasoconstrictors are contraindicated. Atropine, stramonium and scopolamine enhance its pressor effect.

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SMITH, KLINE & FRENCH LABORATORIES, PHILADELPHIA, PA.

Recommended 1942 Normal Budget $55,625

8. *Assistant secretary, salary.*—George B. Larson, now acting secretary, has remained at the salary established on July 1, 1940, of $3,300. The amount suggested represents an annual increase of $450 for the position of assistant secretary ____ 3,750

9. *Assistant secretary, travel.* — This constitutes the same appropriation as that of 1941 and enables the assistant secretary to attend certain committee meetings and other functions _____ 300

10. *Lucia Stolp.*—Miss Stolp came to the Society from the Mayo Clinic in May, 1936. She has general charge of the office, supervising in particular all purchase of supplies and office expenditures. She assists in many of the secretary's administrative details. Her present salary was established on January 1, 1941.

11. *Hayden Smith.* — Mr. Smith has court reporter abilities, and has traveled the state with the Committee to Study the Distribution of Health Services and Sickness Care and the Committee to Study Hospital Insurance. He takes all legislative hearings on public health matters, proceedings of the committees that must be reported, and assists in the contact and study work with state officers and departments at Madison. The present salary was established on January 1, 1941. $6,660

12. *Helen Brandt Newby.*—Since Miss Ripley left the Society in September, 1939, Mrs. Newby (formerly Miss Brandt) has had full charge of the membership records which, with press service, fully occupies her time. Her present salary was established on June 1, 1941.

13. *Ethel Wichern.*—Miss Wichern is stenographic assistant to Mr. Larson. The present salary was established on June 1, 1941, but she is now employed only half-time (see below).

14. *Regular help, employed part-time.* With the death of the secretary, and due to the fact that one of the secretarial assistants has been placed on part-time so that she may attend the University of Wisconsin during the school year of 1941–1942, the office requires the full-time services of one additional stenographer. The amount provided for 1942 is to permit this, and to assist the office in meeting with dispatch the demands made upon it. Mrs. Alberta Wolfe Marquardt, a former employe of the Society, is now temporarily doing this work _____ 700

Special note re staff.—Miss Stolp also receives moderate compensation from the funds of *The Wisconsin Medical Journal* due to her added responsibilities in that work. The present full-time assistant employed by *Journal* funds is not sufficiently trained to edit the magazine without help and supervision. No raise is suggested as to any employe, although justified from the value of their work and rising living costs. It is suggested that the secretarial office be permitted certain privileges in this connection from appropriation 14.

Total, items 8 to 14, inclusive ___ $11,410

III. *Administrative Expense*

15. *Accounting and insurances.*—This item includes provision for the part-time services of the bookkeeper for the books of the secretary and treasurer, the cost of the annual audits, and the various insurances carried by the Society such as fire, workmen's compensation and public liability (1941 appropriation $750) __ 750

16. *Social security taxes.*—The Society is subject to the social security laws and is complying with the Wisconsin unemployment compensation law. This appropriation is fixed in its nature, but due to our unemployment reserve having now reached its required total, the amount listed is one-half that required in 1940 __ 335

17. *Office*

A. *Rent.*—The present quarters were secured with approval of the Council to reduce fire hazard to irreplaceable and invaluable records in an old building. The total rent of the offices of the State Medical Society and *The Wisconsin Medical Journal* is $2,340, the balance of $540 being paid out of *The Journal* fund __ 1,800

B. *Telephone and Telegraph.*—The amount allocated for 1942 is an absolute minimum. The 1941 appropriation was $600. This proved insufficient by $250 _____ 700

C. *Supplies and Light.*—This item covers mimeograph stencils, mimeograph paper, second sheets, typewriter ribbons, and like items of normal office requirements, and office lighting. It is anticipated that the cost of supplies will advance at least 10 per cent during 1942, perhaps more. The 1941 appropriation was $750, which proved inadequate. However, rising costs may be offset in time by certain economy measures, such as use of both sides of mimeograph paper 800

D. *Postage and Printing.*—The printing referred to is essentially stationery. The postage bill of a normal outgoing mail of fifty pieces, first class, per day, seems to be an irreducible item.

(Continued on page 164)

Application Blank, Physicians' Hobby Show

One Hundred First Anniversary Meeting

Milwaukee Auditorium, September 14, 15 and 16

Tear out this application blank for the purpose of reserving exhibit space at the Physicians' Hobby Show to be presented in the exhibit hall of the main arena of the Milwaukee Auditorium.

Acceptable exhibits include photographs, sketches, wood working, wood carving, stamp collections, metal spinning and similar hobbies.

Indicate with an X, in the list of subjects below, the hobby which you wish to exhibit, and mail your application at once to Dr. Smiles at the address given.

C. J. Smiles, M. D., Director of Scientific Exhibits
State Medical Society of Wisconsin
917 Tenney Building, Madison, Wisconsin
Dear Dr. Smiles:

I wish to make application for exhibit space at the Physicians' Hobby Show to be presented in connection with the One Hundred First Anniversary Meeting of the State Medical Society of Wisconsin.

My hobby exhibit will require _____ lineal feet of space (six feet high).

My exhibit will be on the following subject (subjects):

Bells _____	Paintings _____
Books _____	Prescriptions _____
Clay modeling _____	Sculpture _____
Coins _____	Sketches _____
Dishes _____	Soap carving _____
Documents _____	Stamps _____
Etchings _____	"Still" photographs _____
Firearms _____	Surgical instruments _____
Floriculture _____	Swords and knives _____
Glassware and glass blowing _____	Taxidermy _____
Jewelry _____	Weaving _____
Manuscripts _____	Wood carving _____
Match covers _____	Wood working _____
Metal spinning _____	_____
Metal working _____	_____
Model railroads _____	_____
Motion pictures _____	NAME: _____
Musical instruments _____	ADDRESS: _____

	Recommended 1942 Normal Budget $55,625
In addition, this item covers the membership certificate mailing, correspondence and postage for our bulletins to committees and officers. While some economies are being effected, these will be offset by increased costs that are beyond our power to control. The 1941 appropriation of $2,100 was barely sufficient	$2,300
E. *Fixtures and Upkeep.*—The Society finds it essential to purchase a file, and sometimes two, a year; to replace two typewriters of seven; and to provide for repair of others; and like incidental expenses of normal upkeep. Because of careful purchasing in 1941 in anticipation of rising prices and scarcity, the normal annual expense of $400 may be distributed over a two-year period or, if necessary, may be dropped below that figure temporarily	200
F. *Miscellaneous.*—In the statement of the budget figures above, the minimums have been used. Each year, however, finds us confronted with situations, emergent in their nature, requiring either a wholly new and unanticipated expense of over-the-budget expenditures. An example, for instance, will be a year when five bulletins to members, costing $600 instead of the budgeted $450, are required. This item is to permit a leeway to this limited extent. The 1941 appropriation was $450, which proved slightly insufficient	500
Total administrative expense—(1941 total $7,400)	$7,385
IV. *Membership—special service*	
A. *General*	
18. *Legal.*—The State Society prepares contracts between county medical societies (where arrangements can be made) and local relief authorities for provision of sickness care for those on public assistance rolls. The State Society is frequently called upon by county societies to advise them as to membership rights and related questions. Occasional problems of emergency character are presented, such as that in 1941 when the Society appeared in the Supreme Court on the subject of expert witnesses. Officers of the Society themselves frequently must resort to legal counsel in order to safeguard the general policies of the Society, and further work carried on under this appropriation includes advice to members concerning problems which affect the profession at large, assistance in interpretation, and participation under various relief laws, analysis of other laws peculiarly affecting the profession of medicine, and compilation of the Blue Book material (1941 appropriation, $1,800)	$1,500
19. *Special Bulletins to Members.*—With a membership of 2,550, a single special bulletin to the members costs $150, perhaps more in 1942. Experience of past years indicates annual requirement of at least four of these. A decrease in the number of resident members would permit a smaller appropriation. The 1941 appropriation was $600	500
20. *Blue Book Issue.*—This represents but the excess printing and mailing costs for this annual issue of *The Journal,* which is continually revised and new material incorporated. The size of the Blue Book issue has been substantially increased, and reprints of special articles are in greater demand. While the normal budget appropriation has been $600 in the last two years, this is barely sufficient	600
B. *Scientific*	
21. *Annual Meeting.*—$1,800 represents the cost to the Society over exhibit income for a normal year	1,800
22. *Graduate Centers.*—This represents the largest possible loss. In 1941, of $900 appropriated, only about $500 was spent. It would be unwise to reduce the appropriation to less than that suggested in 1942, as inclement weather or a similar occurrence may result in a small registration with a consequent large financial loss. It is suggested that any surplus be transferred to the annual meeting account automatically	900
23. *Wisconsin Medical Journal.*—See secretary's report in the February, 1941, issue of *The Wisconsin Medical Journal* for discussion and itemized report of 1940 financial experience. It is to be especially noted that *The Journal* is self-supporting on the basis of 75 cents per member per year from the general fund. This is the lowest cost per member of any state journal. While the 1941 appropriation was $1,800, the House of Delegates recognized and accepted the need for an additional amount to permit publication of a greater volume of scientific articles	2,100
Special Note: The Journal and the annual meeting are among the most essential activities of the Society. Savings in publication costs and advantages of in-	

	Recommended 1942 Normal Budget $55,625
creased advertising rates will be offset by rising prices. The annual meeting is 75 per cent self-sustaining through revenue from exhibitors. The only adjustment thus indicated is further reducing graduate centers to two meetings instead of the three proposed for 1942, or a reduction of the number of speakers.	
Total membership—special services (1941 total, $9,300)	$7,400
V. *Public health, special services*	
A. *Normal service*	
24. *Hygeia.*—This is authorized as a standing appropriation to present at Christmas time, a year's subscription to all state officers, the nine state teachers' colleges and certain others who have to do with public health problems and procedures	250
24. *Health and Public Instruction.* This item represents the printing, paper and postage costs of furnishing a weekly story on health and its further attainment, to weekly and daily papers of the state. Added for the year 1942 is the amount required to operate three health exhibits at county fairs and the state fair, and to accept the offer of radio station W H A of free time to make a short weekly broadcast on matters of health and national defense	$1,135
26. *Lay Publications.*—Item represents cost of furnishing health studies, documents and pamphlets to state officers and others who have to pass upon health procedures and proposals (1941 appropriation, $450)	400
27. *Bulletins to Members.*—Cost of bulletins dealing with proposed changes in public health laws and rulings	500
28. *Special reports in The Journal.*—Supplements or insert sections dealing with state and national health problems	250
29. *Telephone and telegraph.*—Dealing with health legislation (1941 appropriation $450)	450
30. *Services, general counsel.*—Analyzing all legislation to ascertain which deals with health subjects, compilation of data concerning legal effect of changes proposed, and assisting in discussion with and in official bodies (1941 appropriation, $1,750)	1,500

(Continued on page 166)

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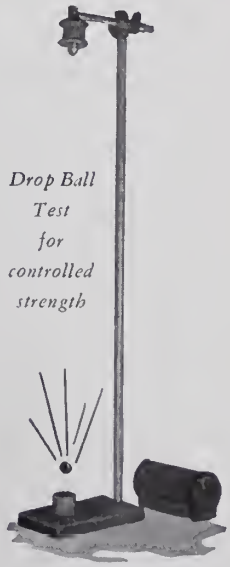

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	Recommended 1942 Normal Budget $55,625
B. *Voluntary sickness insurance trials.* In 1940 this item was budgeted at $3,700, of which amount but $2,643.77 was used. In 1941, of the appropriation of $2,000, only $700 was used. While now no current trials are being operated, necessity continues for the budget allocation in that plans of other states, as Michigan, must be followed closely, as the Society necessarily must be informed and continue its authoritative position. No action of a new nature will be taken without committee action, or of an important nature or commitment without the Council's approval	----
Special Note: It is recommended that the unused balance in the 1941 budget be treated as a standing reserve for the work of this committee, with no new appropriation in the 1942 budget. Under this policy, the balance of the 1941 appropriation would not be formally treated as part of the surplus, but would be available during 1942 and subsequent years if need became apparent. In the budget presented before the House of Delegates, $750 was suggested as necessary for 1942, but constituted an appropriation from 1942 income.	
Total, public health, special services (1941 total, $6,110)	$3,810
VI. *Industrial health program*	
A. *Panel Preparation and Distribution Explanatory Note:* The three-phase program suggested for 1941 was not fully carried out, due to inability to secure a full-time physician coordinator of the whole program. In the proposal before the 1941 House of Delegates, this position was abolished in view of the costs of panel preparation and distribution. In the 1941 budget this was estimated at $2,600 which proved, because of erroneous figures given us as to the number of employers in the state, insufficient to the extent of $1,500. It is proposed that under the normal budget, this program be carried forward without interruption, but if membership income necessitates, the program can be carried out on *two* occasions over the next *three* years	4,200
B. *Physical Examination in Industry* The physical examination in industry will be a pressing problem in 1942 and subsequent years. Obviously, it will become part of a national defense program instead of an industrial health program. Our own program will be dwarfed by that which will be suggested from other sources. We must be prepared to study, analyze and participate. While the 1941 appropriation of $1,000 seemed adequate at that time, the present appropriation of $1,500 is suggested, with the unutilized 1941 appropriation held in a special reserve account	1,500
Total cost of industrial health program	$5,700
Total budget (1941—$57,286.50)	$47,055
Unappropriated income available for emergency requirements, or surplus, about	9,000

Following discussion by all officers and councilors, and upon motion by Christofferson–Fitzgerald, the budget was adopted unanimously.

13. Report of Committee on Hospital Relations

The Committee on Hospital Relations, composed of Dr. R. M. Kurten, Racine, chairman; Dr. R. M. Waters, Madison; Dr. M. L. Jones, Wausau; Dr. J. E. Habbe, Milwaukee; Dr. E. O. Gertenbach, Milwaukee, and Dr. Gorton Ritchie, Racine, recommended to the Council, the development of a portion of the annual meeting program embodying suggestions of interest in the administration of certain professional routines within hospitals. Speaker Kurten, as chairman of the committee, discussed a possible series of subjects that could be utilized in the formation of such a program. Following discussion by Drs. Kurten, Krahn and Fitzgerald, and upon motion by Lambert–Bowen, the Council expressed its approval, in principle, of the objective sought by the committee and referred the proposal to the Council on Scientific Work for further conference with the committee in the light of Council action. Carried unanimously.

14. Appointment of Committees of the Council

Chairman Gavin announced the appointment of the following committees of the Council: *Auditing Committee*—Councilors Christofferson, chairman, Krahn and Gramling. *Executive Committee of the Council*—Councilors Clark, Heidner and Blumenthal. *Conference Committee on Open Panels*—(representing the State Medical Society of Wisconsin) Dr. T. J. O'Leary, Superior, and Dr. R. M. Kurten, Racine. *Wisconsin Hospitals and Medical Payments Plan*—(representing the Society) Dr. C. H. Andrew, Platteville, and Dr. A. E. Rector, Appleton. *Committee on Medical Defense* (formerly M–Day Committee)—Dr. R. E. Fitzgerald, Wauwatosa, chairman; Dr. J. W. Lambert, Antigo; Dr. Robert W. Blumenthal, Milwaukee, and Dr. C. N. Neupert, Madison.

Upon motion by Councilor Christofferson, duly seconded, the appointments by the chairman were approved.

15. General Practitioner Section Meeting at Next Annual Meeting of the American Medical Association

There was discussion of the resolution adopted by the House of Delegates of the Society at its

1941 session, introduced by Dr. R. L. MacCornack, Whitehall, in which the Council was instructed to urge a large attendance of general practitioners from the membership of the State Medical Society at the experimental session of the General Practitioner Section of the American Medical Association's annual meeting in 1942. It was the decision of the Council that this was an effort which should be considered and advanced by the individual county medical societies, with publication of an appropriate item in *The Wisconsin Medical Journal.*

16. Report of The Committee on Medical Defense

The report of Dr. R. E. Fitzgerald, chairman of the Committee on Medical Defense (formerly the M–Day Committee), appears in the section of *The Journal* designated as "The Nation at War," p. 132.

17. Health Surveys

Proposed health screening surveys and participation by the medical profession of Wisconsin were discussed by Councilors Pippin, Blumenthal, Christofferson, Clark, Jegi, Krahn and Heidner, Secretary Crownhart and Assistant Secretary Larson. No action was taken, it being the sense of the Council that this was a subject requiring further study and correlation, and one which should be referred to the Executive Committee of the Council as the subject is developed further.

18. Special Classification of Dues-paying Members

Based upon action of the House of Delegates at its 1941 session, the matter of the Society's establishing a special dues-paying classification of membership was referred to the Council for further study. It was suggested that such a special classification of members would include hospital residents and research fellows who often are unable to become fully paid members of the Society.

Upon motion by Clark–Fitzgerald, this entire subject matter was referred for further consideration to the Special Committee to Study the Constitution and By-Laws.

19. Appointment of a Committee to Seek Additional Funds for Psychiatric Institute

At the request of Dr. W. F. Lorenz, Madison, director of the Wisconsin Psychiatric Institute, this matter was presented to the Council. It was stated that unless additional funds are secured, the Institute could not continue to furnish blood chemistry services to the physicians of the state.

Upon motion by Clark–Heidner, the chairman of the Council was instructed to appoint a committee to take necessary action toward furthering the possibility of securing such additional funds from the state treasury.

20. Adjournment

The meeting adjourned at 4:00 p. m.

C. H. Crownhart
Secretary

Approved:
S. E. Gavin
Chairman of the Council

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BROWN—MANAGEMENT OF ENDOCERVICITIS

(Continued from page 120)

both ends of the wire. The size of the loop may also be adjusted to that desired by the operator. These electrodes have seen service for several months at a time before requiring attention and can even be dropped without breaking.

I believe in the removal of diseased cervical tissue by conization and the control of bleeding points by coagulation with a small ball-shaped electrode. Sutures are only occasionally required to control bleeding and this is usually in a case of marked inflammatory reaction with blood vessels of unusual calibre being encountered. Crossen & Wulff[9] have well described the use of sutures in such cases. Use extreme caution to be sure that the indifferent electrode is making proper contact with the patient so that the danger of a burn may be avoided. Each high frequency machine used must be adjusted to give the type of current desired. The loop must not cut too quickly or bleeding may result, or too slowly or coagulation will be excessive.

The time of surgical treatment of the cervix is important. The optimum time is during the week after the menses cease or about mid cycle. Healing may be quite well advanced before the next menses.

The complications which may occur in a series of patients treated by extensive cauterization, coagulation or conization are stenosis, hemorrhage and pelvic infection or abscess formation. Avoid carrying out any of these procedures in the presence of an acute cervical infection. If in doubt, treat the patient conservatively for a while and pick the optimum time for surgical intervention.

It is well to insert a double T tube made with Dakin tubing after conization and allow it to remain in place for a week or ten days. It acts as a core about which the cervix heals and maintains drainage from the uterine cavity. The cervical canal should be tested for patency in one or two weeks by means of a uterine dressing forceps. This procedure should be repeated at monthly intervals until the patient has passed through three or four menses. By this follow-up stenosis can usually be avoided. Scar tissue formation is minimal and many pregnancies have occurred subsequent to this type of treatment, and dilatation of the cervix has progressed normally. Lactic acid douches should be ordered four or five days after conization and will aid greatly in hastening healing and in eliminating the offensive odor of the discharge.

Conclusions

1. Cervicitis and vaginitis constitute a pathologic syndrome.
2. Differential diagnosis is of great importance and will lead to enlightened therapy.
3. Early recognition of malignancy is of vital importance to the patient. When in doubt obtain a biopsy of the suspicious area.
4. In cases in which evidence of infection is lacking, endocrine check-up may give the clue to the diagnosis and suggest the proper therapy.
5. Treatment should be an attempt to restore the normal physiology of the vagina as promptly as possible and maintain it.
6. If diseased cervical tissue interferes with the maintenance of the normal physiology of the vagina, removal of this tissue should be accomplished by means of conization and spot coagulation.
7. Complications can be avoided by proper preparation of patients and care in selecting the proper time for operation.

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8. Proper follow-up of patients will lead to improved final results.

9. The suggested treatment will not interfere with subsequent pregnancies nor complicate future deliveries.

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LORENZ—SYPHILIS IN WISCONSIN

(Continued from page 122)

1,000. In nine large cities cited this is the lowest rate found, by a considerable margin.

This good showing in Wisconsin is believed to be entirely due to the very active antisyphilitic program that has been carried on in Wisconsin for over twenty-odd years. The greatest credit should go to the Wisconsin State Board of Health, although this accomplishment would not have been realized had not the general medical profession cooperated to the same end. The statewide available serologic service in blood tests and cerebrospinal fluid examinations by the Wisconsin Psychiatric Institute which began over twenty-five years ago has also contributed a part to this achievement.

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PRICE AND PERSONIUS—WISCONSIN CHEESE

(Continued from page 128)

Swiss also belongs in a separate grouping of hard cheeses ripened by bacteria. They are characterized by large gas holes.

Parmesan is a cooking cheese of Italian origin and of minor importance.

The different types of cheese that have been listed here by no means exhaust the field. In most European countries each community has a definite set of names for varying types of cheese, and since even in a scientifically controlled laboratory it takes great care to keep cheese flavor uniform, the number of different flavors and colors and types of cheese in Europe is large, but not surprising. A Department of Agriculture bulletin by Doane and Lawson points out that there are probably not more than a dozen distinct types of cheeses, but minor variations and geographical differences boost the number of names to the hundreds.

Modern science has partially failed in giving due attention to cheese. It is one of the oldest foods known, yet scientific research has not emphasized its food value.

Science Still Studies Cheese

Certainly some questions have not been answered definitely. A few scattered tests have been conducted comparing the digestibility of different types of cheese, and one conducted by Moen recently on Norwegian Gouda seemed to indicate that the aged cheese is almost completely utilized (99 per cent) in the digestion process. But certainly the question has not been explored as thoroughly as it should be.

Nor does anyone know the exact content of certain B-complex vitamins in cheese. There is evidence that certain of the B-complex vitamins are present, but the task of measurement is not yet completed.

But though fewer nutritive studies have been made of cheese than of some other foods, each succeeding investigation reemphasizes its importance. Cheese supplies protein building blocks and energy, both in great concentration and in easily available form. It is a complete protein food, which means that it contains all of the essential amino acids which are necessary to support life and promote normal growth. It carries both vitamins and minerals. Along with milk it plays a major role in supplying calcium needs.

The important thing is that cheese is a rich, health promoting food. The claims long made for it, science is now able to authenticate, and new scientific discoveries can only add to the reputation it has justifiably acquired as a food for health.

THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

The Medical Clinics of North America. Boston Number. Volume 25, Number 5. Cloth. Price $16 per clinic year. Pp. 328, with 30 illustrations. Philadelphia: W. B. Saunders Company, September, 1941.

This symposium on specific methods of therapy includes articles on the common forms of heart disease, pneumonia, diabetes, pulmonary tuberculosis, diphtheria, scarlet fever, bacterial meningitis, migraine, epilepsy, exophthalmic goiter, peptic ulcer, gallbladder disease, amebic and bacillary dysentery, nephritis, urinary tract infections and infant feeding. In addition, the use of vitamin K, preventive medicine, and the clinical application of electroencephalography are discussed.

In the articles on pneumonia, meningitis, and urinary tract infections, the lag in publication has resulted in the failure of inclusion of some of the newer sulfonamides, notably the use of sulfadiazine

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in meningococcic infections. However, in spite of this, these articles are very well done and worth the study of anyone treating these diseases.

The discussion of preventive medicine is an excellent review of the present day status of active preventive measures.

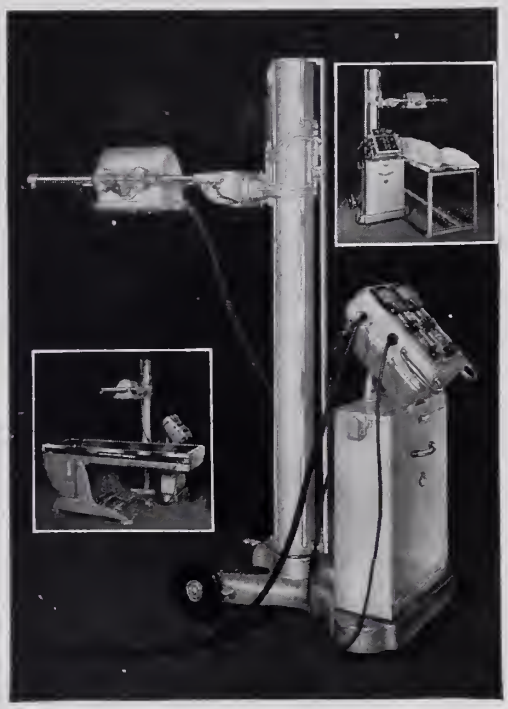
Although several of the articles present no new methods of therapy, the review and evaluation of present treatment makes them valuable.

Throughout, the articles are concise, and the exact method of therapy including the dosage of the various drugs is stressed. For anyone in the practice of general medicine this book is worth reading and having available for reference. H. A. D.

The Art and Science of Nutrition. A Textbook on the Theory and Application of Nutrition. By Estelle E. Hawley, Ph. D., and Grace Carden, B. S., The University of Rochester, School of Medicine and Dentistry, Rochester, New York. Cloth. Price $3.50. Pp. 619, with 140 illustrations including 12 in color. St. Louis: The C. V. Mosby Company, 1941.

The title of the volume is well selected, and the material it presents should be valuable not only to nurses, for whom it is designed, but also to anybody responsible for the selection or preparation of adequate dietaries in either disease or health. The space given to discussion of the rôle of adequate nutrition in preventing borderline deficiency states and in promoting optimal rather than just passable health is in accord with the growing realization of the importance of this consideration for both personal and public good. In providing for individuals who are sick, the point of the authors is well taken, that the busy physician has time as a rule merely to indicate what sort of diet he wishes to prescribe, leaving the details of actual selection to others. When the services of a professional dietitian are not available, this often devolves upon the nurse.

The book is well printed and generously illustrated. It includes sections on the background of normal nutrition, food requirements under special physiological conditions (pregnancy, growth, old age, etc.), and those for a variety of diseases. There is guidance for selection, preparation and serving of foods, recipes and suggested exercises for invalid cookery, and an appendix with food tables, food equivalents, vitamin and mineral contents, representative special diet menus and methods of calculation, and much other reference material of practical usefulness. In discussing the medical background of different conditions for rationalizing accepted methods of diet therapy, it is not surprising that an occasional statement runs counter to widely accepted medical opinion—as, for example, disparagement of the usefulness of adrenal cortical extracts in the treatment of Addison's disease (p. 286); but this is, of course, not vital to the general purpose of such a book. Occasional typographical errors that escaped the proofreader ("increased," rather than "decreased" blood volume in Addison's disease, p. 296; omission of a line middle of p. 287, for example) will doubtless be remedied in later editions of this attractive and very worth-while work. M. S. K.



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BOOK REVIEWS—Continued

Diseases of Women. By Harry Sturgeon Crossen, M. D., F. A. C. S., professor emeritus of clinical gynecology, Washington University School of Medicine; gynecologist to the Barnes Hospital, St. Louis Maternity Hospital, and St. Luke's Hospital; consulting gynecologist to the De Paul Hospital and the Jewish Hospital; fellow of the American Gynecological Society and of the Central Association of Obstetricians and Gynecologists, and Robert James Crossen, A. B., M. D., assistant professor of clinical gynecology and obstetrics, Washington University School of Medicine; assistant gynecologist and obstetrician to the Barnes Hospital and the St. Louis Maternity Hospital; assistant gynecologist to the St. Louis Children's Hospital; gynecologist and obstetrician to St. Luke's Hospital and to De Paul Hospital; fellow of the Central Association of Obstetricians and Gynecologists; diplomate of American Board of Obstetrics and Gynecology. Ninth Edition, entirely revised and reset. Cloth. Price $12.50. Pp. 948, with 1,127 engravings, including 45 in color. St. Louis: The C. V. Mosby Company, 1941.

This text has been reorganized and well written, with much of the old material deleted and new material added, which is to be commended. In fact, I feel this book is second to none in the field. It needs no defense, with my recommendation that it should be a part of the library of every obstetrician and gynecologist. R. E. C.

The Medical Clinics of North America. Mayo Clinic Number, Vol. 25, No. 4. Cloth. Price $16 per clinic year. Pp. 302, with 88 illustrations. Philadelphia: W. B. Saunders Company, July, 1941.

This book gives the reader a concept of the values, principles, and limitations of radium and roentgen therapy.

The treatment of uterine cervical carcinoma, carcinoma of the female genitalia, carcinoma of the rectum, and of non-malignant lesions is discussed.

The article on roentgen therapy of malignant tumors is written purposely to answer the question of the general practitioner as to the usefulness and advance in this method. To this end an excellent presentation of the principles and various types of therapy, together with their application in the different diseases amenable to roentgen therapy, is given.

From the standpoint of roentgen diagnosis, articles on pelvimetry, bone tumors, contrast myelography, tumors of the scalp, gastric ulcer, gastric carcinoma, and intestinal obstruction are included. These are designed to give the average physician an understanding of the significant x-ray changes, rather than to instruct him in the specialty of roentgen diagnosis.

A timely article on the dangers to the physician himself from the careless use of roentgen apparatus is a warning that should not be overlooked. H. A. D.

Infant Nutrition. A Textbook of Infant Feeding for Students and Practitioners of Medicine. By Williams McKim Marriott, B. S., M. D., late professor of pediatrics, Washington University School of Medicine; physician in chief, St. Louis Children's Hospital, St. Louis. Revised by P. C. Jeans, A. B.,

BOOK REVIEWS—Continued

M. D., professor of pediatrics, College of Medicine State University of Iowa, Iowa City. Third Edition. Cloth. Price $5.50. Pp. 475, with 31 illustrations. St. Louis: The C. V. Mosby Company, 1941.

Under the able editorial guidance of Dr. Jeans this deservedly popular book has once more been brought up to date. Keeping a book on nutrition up to date is a difficult task these days and how soon further revisions will be necessary nobody can tell. The changes in the new edition are largely those of amplification but with such a vast amount of new material available on some subjects, for example vitamins, this just about means rewriting certain chapters, notably those on the vitamins and rickets. H. K. T.

Rheumatic Fever in New Haven. Edited by John R. Paul, M. D., professor of preventive medicine, Yale University School of Medicine. Paper. Price $1. Pp. 176, with 45 illustrations. Lancaster, Pennsylvania: The Science Press Printing Company, 1941.

This book is a collection of papers by several different authors, each of whom has undertaken to study one or more of the epidemiological aspects of rheumatic fever in an industrial city of about 160,000 people where the incidence of this disease has been found to be very high.

Epidemiologically, rheumatic fever is defined as "a disease of childhood and a crowd disease which is commonest in the temperate climates among urban people." It is the avowed purpose of the authors to add something to the above definition. Several important facts are established about rheumatic fever in this particular community which in general agree with those of other studies done elsewhere.

Prevalence determinations are based on three different methods of analysis; namely, analysis of local hospital admissions rate for rheumatic fever, determination of local prevalence of rheumatic heart disease in school children, and the analysis of mortality statistics for heart disease in young people. From the first method it was found that 2.7 per cent of all medical admissions studied were for acute or chronic rheumatic fever. This compared with previous reports from the nation at large of an average of 2.5 per cent and of a rate in children's hospitals alone collected from all over the country of 5.6 per cent. The New Haven rate of 2.7 per cent would be about 29 cases per 100,000 population. Thus, rheumatic fever is the third most common of the infectious diseases in New Haven insofar as it could be determined from local hospital admissions. Tuberculosis and syphilis were more common. The prevalence of rheumatic heart disease in New Haven school children is reported as 3.1 per cent and this is lowered to 2.5 per cent if one of the residential and suburban districts is included. From the third method of analysis above the writers report an incidence of .115 per 1000. In arriving at this figure it was considered that 80 per cent of all cardiac disease in people under 25 years of age is rheumatic heart disease.

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BOOK REVIEWS—Continued

Nothing new is added to our knowledge of the etiology of rheumatic fever and this still remains obscure. However, the following relationships of rheumatic fever to scarlet fever, tonsillitis and erysipelas were found to be true in this study. (1) All of these diseases are most prevalent in February, March and April. (2) The winter peak of rheumatic fever seems to lag consistently about one month behind that of the other diseases mentioned. (3) With regard to acute tonsillitis, erysipelas, and rheumatic fever there seems to be a little variation in the incidence from year to year—"a good year for one is a good year for the other." (4) There is a wide variation in the incidence of scarlet fever and no correlation was observed between this incidence and that of rheumatic fever.

The contention that rheumatic fever is a disease which finds lower incidence among people of ample means was supported by the authors' studies of the incidence of rheumatic heart disease in the undergraduate student body at Yale. Here they found an incidence of rheumatic fever of 8.2 per 1000 as compared with 15 per 1000 as an average for a comparable age group in other walks of life. In like manner studies of the incidence of rheumatic heart disease in 5,758 public school children revealed that rheumatic fever and rheumatic heart disease were 1.5 times as prevalent among children of the poorer districts than among those from the better districts of the city.

In studying the dispensary cases from the social and geographical distribution, it is again confirmed that there is a definite trend to a low case or hospital rate for rheumatic fever with the best living conditions and a high case rate for the worst ones. As far as racial trends were concerned, it is again confirmed that the Irish are most susceptible and that the Negro race suffers with increased severity of infection.

The "Rheumatic family" is studied from various aspects in one article and one of the most interesting points brought out is that in rheumatic families the disease usually appears first among the older siblings and later among the younger ones as they reach the ages of 6 to 12. The authors feel that although epidemics in the same family do occur, they are the exception rather than the rule. They further suggest that this timing of the appearance of the disease in different members of the same family lends strength to the contentions of those who feel that the susceptibility and sensitization of individuals is important in the development of rheumatic fever.

In summary it would seem that the main value of this work lies in the fact that more data is carefully collected and organized to support some common theories of the epidemiological aspects of rheumatic fever. Furthermore the methods used should serve as a guide to further similar studies which should be undertaken in different parts of this country in an attempt to shed more light on this all important problem. D. E.

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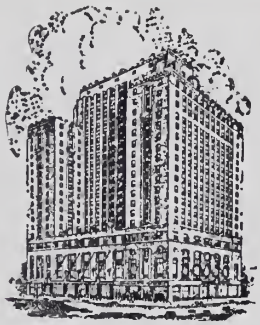

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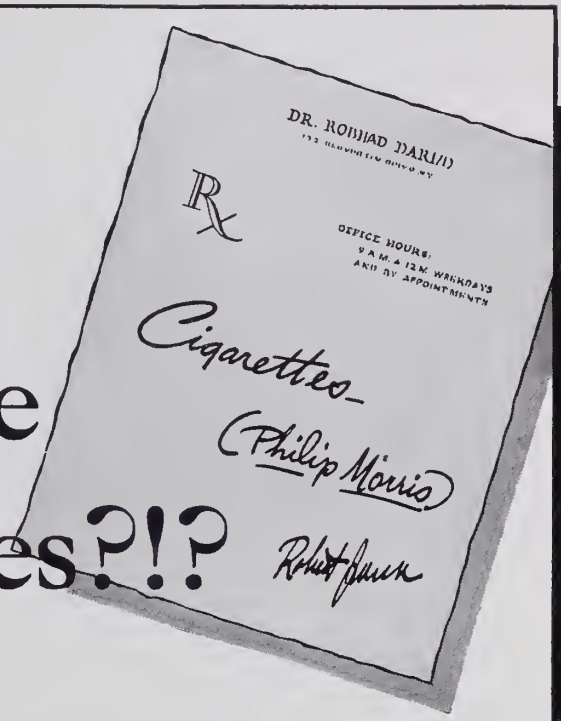

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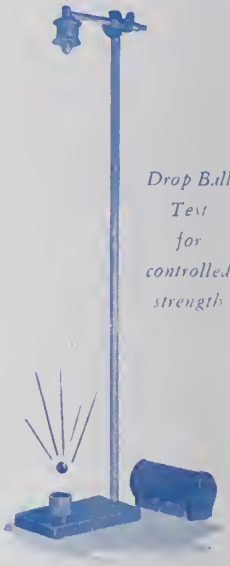

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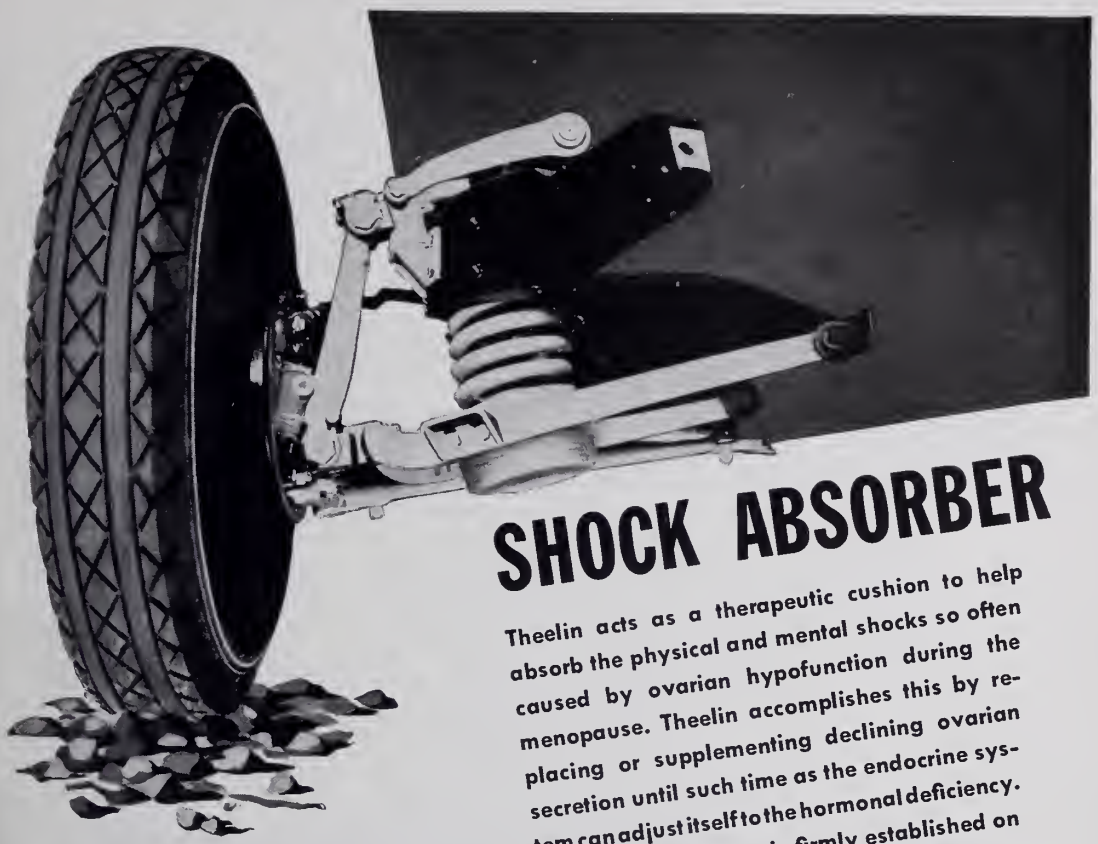

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[Entered as second class matter, June 30th, 1903, at the Post Office at Milwaukee, Wis., under Act of Congress March 3rd, 1879. Transferred to Madison, Aug. 1st, 1929.]
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(1) 1936. Food Research 1, 3
1936. Ibid 1, 231
1938. Nutrition Abstracts and Reviews 8, 281
1939. The Canned Food Reference Manual, American Can Co., New York.
1940. J. Am. Diet. Assoc. 16, 891

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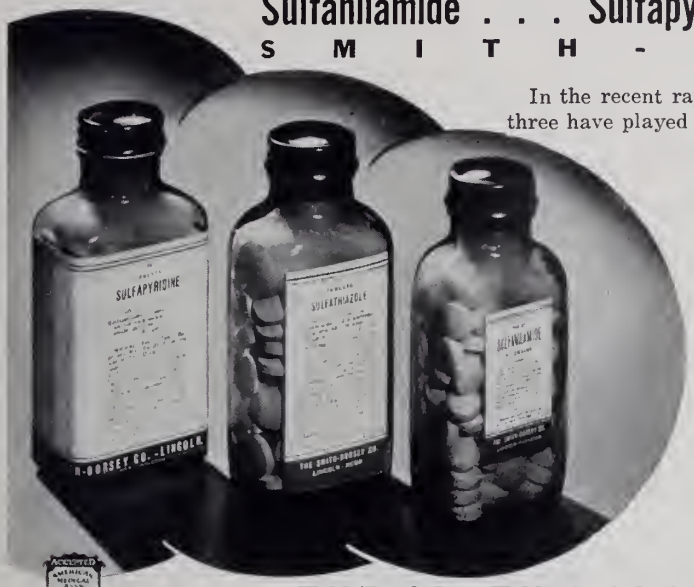

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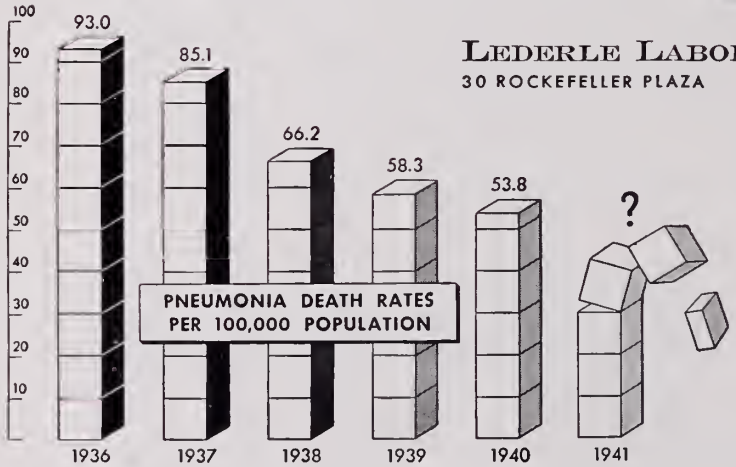

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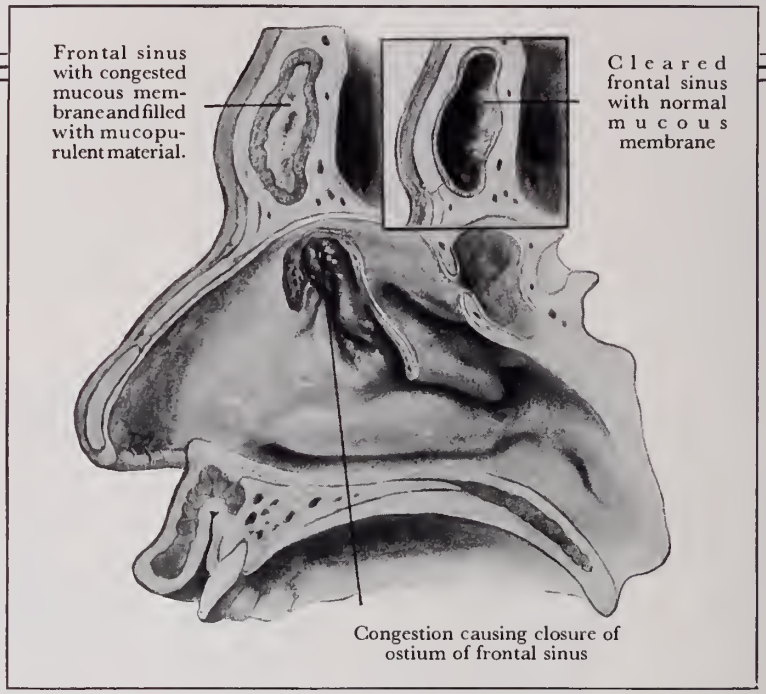

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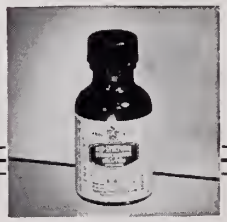
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THE WISCONSIN MEDICAL JOURNAL

VOLUME 41, NO. 3 Copyright, 1942, by The State Medical Society of Wisconsin MARCH, 1942

Modern Trends in Treatment of Hypertension

With Special Reference to the Use of the Kidney Anti-Pressor Substance

By FRANCIS D. MURPHY, M. D.*

Milwaukee

Historical Material

THE role of the kidneys in the production of hypertension has been an inconstant one. Opinions have shifted from one extreme to the other, earlier writers believing that kidney disease was the main cause of high blood pressure, while later, others viewed the renal disturbances merely as end results with little or nothing to do with the genesis of hypertension. In Bright's day (1827) and for fifty years afterward, hypertension was believed to be caused by renal disorders; then followed another period of about fifty years in which the kidney was assumed to have little or no part in the etiology of hypertension. And now the pendulum has begun to swing back again and the kidney once more is considered the chief offender in the causation of hypertension.

Bright[1] wrote cautiously concerning the relationship of the kidney to cardiac hypertrophy, arterial changes and increased arterial tension, but regarded the kidney as the main offender. A review of the opinions of those who came immediately after Bright shows that the kidney was thought to be diseased first, and the increased pressure and associated phenomena were consequences. Some authors were more specific than Bright. For example, Johnson[2] believed diseased kidneys failed to excrete toxic substances, which were held in the blood stream, and the peripheral arterioles clamped down to protect the cells of the body from their noxious influence, thereby producing high blood pressure. Traube[3] thought the kidneys failed to filter off water and the resulting plethora hydraemica caused hypertension.

The trend away from the kidney influence began when Gull and Sutton[4] and Mahomed[5] published their classic papers describing the minute changes in the small arteries and arterioles. These investigations established the disease as one primarily of the arterioles and capillaries, often involving the kidney little or none at all, though the vascular changes may be advanced in other organs. The clinicians labeled the disease "primary" or "essential" hypertension, while pathologists named it "arteriocapillary fibrosis" or "arteriosclerosis." For nearly fifty years following the research work of Gull and Sutton, the most advanced authorities on the subject sought to establish their beliefs that the kidney disturbance was not an important factor but merely a small part of the disease, and that the sequence of events was hypertension, arteriosclerosis and cardiac hypertrophy, followed finally by heart failure, apoplexy or occasionally uremia.

Allbutt,[6] Janeway[7] and Volhard and Fahr[8] were chiefly responsible for our modern conception of essential hypertension. This condition is featured clinically by high blood pressure without inflammatory or obstructive kidney diseases, and characterized by arteriolosclerosis, cardiac hypertrophy and heart failure in most cases. This simple and almost universally accepted idea of essential hypertension prevailed until recently.

In 1934, Goldblatt's[9] work unexpectedly put an end to the second period of the story of hypertension. With a special clamp applied to the main renal artery, thereby rendering the kidney ischemic, Goldblatt produced hypertension experimentally. According to Goldblatt, if only one main renal artery is constricted, the blood pressure rises but usually returns to normal in six weeks or less. In order to make the hypertension persist, the main artery of the other kidney must be constricted or removed. The belief that a pressor substance of renal origin is liberated and causes the increased peripheral resistance is almost universally held, but the nature of the pressor substance, how it is formed or exactly how it acts are unknown. It is said that it is renin, a pressor substance obtained from normal kidneys, first discovered by Tigerstedt and Bergman.[10] From this experimental work has come a clearer recognition of the fact that unilateral renal disease, as hydronephrosis, renal stone or pyelonephrosis, may be a cause of hypertension in some cases and that the removal of the diseased kidney results in the cure of the high blood pressure.

How the "ischemic" kidney modifies the blood in causing hypertension is not known although several suggestions have been made, as (1) that a pressor substance is liberated from kidney tissue by a change in the blood supply, (2) that there is a failure of removal of a pressor substance which

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already exists, and (3) that there is a failure to liberate an anti-pressor agent which is normally liberated to control blood pressure.

Page[11] was the first to propose a definite explanation of the mechanism of experimental renal hypertension. After proving that renin alone was not the pressor ingredient involved, he observed that it worked in conjunction with an activator found in the blood, forming a pressure-raising substance. He isolated this pressor substance and labeled it "angiotonin." One may epitomize Page's theory as follows: The normal pulsate blood flow in the kidney is partially converted into a continuous flow from interference with the blood supply. Edema and anoxemia of the tubular cells develop and there is an outpouring of renin from the tubular cells. Renin reacts with renin activator in the blood and angiotonin is formed; angiotonin then causes the rise in blood pressure, constriction of the efferent glomerular arterioles and a further liberation of renin from the tubular epithelium. Although this theory has not been proved, it furnishes the most plausible explanation so far, and at least opens up the way for further investigation.

Page and his associates[12] have gone a step further and from kidney tissue they have extracted an anti-pressor substance which they call "inhibitor." Chemical methods for the preparation of kidney extracts have been published by him and other workers.[13, 14, 15] It is Page's belief that the inhibitor neutralizes the renin angiotonin activator and reduces the hypertension. Grollman, Williams and Harrison[16] and Wakerlin and Johnson[17] too have reported on the effects of kidney extracts in the treatment of hypertension. Reports on the use of anti-pressor substance obtained from the kidney are limited since such work is in the realm of clinical investigation and research at present. Workers using extracts realize the importance of refraining from undue enthusiasm in the present stage of their uncertain action. Although results from the use of kidney extracts so far are very encouraging, it remains for future research work and clinical investigation to establish their value in medicine.

The Kidney in Hypertension

Traditionally, hypertension has been classed as primary or essential hypertension and secondary hypertension. Glomerulonephritis, pyelonephritis, adrenal growth, pituitary tumors and other endocrine disturbances may be causes of hypertension. With the more precise study of patients with essential hypertension, many have been found not to be "essential" at all, but "secondary" to some obscure disease as medullary growths, silent renal stones, cysts, congenital anomalies, etc. Nevertheless, primary essential hypertension remains the chief challenger to medicine and it is the kind referred to in this paper.

In the early stages of essential hypertension, the patient is symptomless and the heightened blood pressure is the only abnormality found. Later, the heart enlarges, the arteries harden and the complications of hypertension ensue. The term "essential hypertension" is used to embrace both the so-called benign and malignant forms. In the benign form, the patient usually develops symptoms in the forties or early fifties after having had an elevated blood pressure for five to ten years. Headache, shortness of wind, pain in the chest, visual disturbances or feeling of malaise may cause the individual to seek medical care. In this benign form, the disease runs a slow, placid, benign course and terminates usually in heart failure, stroke or uremia years later.

The malignant form is not a separate and distinct kind of disease but merely a stage or phase of hypertension. It differs from benign hypertension only in degree of severity, speed of progress and ultimate outcome. Both the benign and malignant forms have arteriosclerosis of the renal arteries and arterioles. The malignant type differs in that the arteriolosclerotic process is more widespread and involves many more arterioles than the benign. Malignant hypertension is distinguished further by the presence of necrotic lesions scattered throughout the arterioles of the kidney so that histologically the difference is one of degree, not of kind.

Clinically, malignant hypertension occurs in young people, often in their thirties or younger. The blood pressure, which has been elevated for a year or so, suddenly becomes fixed at a higher point than usual, and then certain events take place. (1) Headaches are almost invariably present and very severe. (2) The diastolic blood pressure which formerly could be found below 110 now cannot be reduced below 130. (3) Loss of appetite, loss of weight and often vomiting develop. (4) There is perceptible general deterioration of health. The downward trend of the disease is rapid and stormy, death coming abruptly within a period of from a few months to a few

years. (5) Lastly, one of the most reliable criteria of the onset of the malignant form are the changes in the eyegrounds. These are characterized by choking of the disks; old and fresh white patches scattered throughout the retina; old and fresh hemorrhages, large and small; and edema of the entire retina which obscures the constricted arterioles of the retina.

Secondary hypertension is the kind associated with an obvious cause, as acute and chronic nephritis, tumors of the kidney, hydronephrosis and bilateral cysts of the kidney.

The kidney requiring surgery refers to one possessing tumors, stones, pus and cysts which, by their removal, cause the blood pressure to fall to normal. How commonly conditions as pyelonephrosis, renal stones or other urological states cause hypertension is a matter of uncertainty at present. Many articles have appeared on the incidence of so-called essential hypertension and organic renal disease, and there is no unanimity of opinion concerning the exact relationship between the two. Among the more recent contributions are those of Schroeder and Steele[18] and Ritter.[19] Braasch, Walters and Hammer[20] made a study of the incidence of hypertension in 975 consecutive cases at the Mayo Clinic to determine the frequency of hypertension in the average adult patients and to compare it with the incidence of hypertension in the so-called surgical kidney. From this comparative study, they concluded that the incidence of hypertension was no higher in the renal group than among those patients who registered consecutively.

Treatment of Hypertension

The modern treatment of hypertension consists of (1) medical treatment, (2) surgical treatment and (3) the use of kidney extracts. It has been commonplace within recent years to say that the medical treatment of hypertension has been a failure, but this is only a half-truth. It would be a grave mistake to believe that the palliative measures used for years by physicians are valueless. Regardless of whether the modern humoral theory of hypertension is finally proved, there are many auxiliary factors to be considered in the cause and treatment of hypertension. A prescription for a proper mode of living has always been an important therapeutic aid. Excessive physical strain, anxiety and intemperance of various kinds are as important in treatment as always.

Medical treatment.—The xanthines, barbiturates and nitrites have been used in the treatment of hypertension, but the good they do is often difficult to assess. Schroeder[21] recently reported that tyrosinase made from mushrooms would reduce high blood pressure in experimental animals and in patients. This material has not been available for general use and information as to its effectiveness is limited.

The thiocyanates were introduced as treatment of hypertension in 1903 by Pauli.[22] Since then, they have been used intermittently, although they were given up for a time because many patients appeared to be made worse rather than better by the treatment. Barker[23] in 1936 brought about a renewal of interest in the thiocyanates by emphasizing the importance of control of the blood cyanate level. If the blood cyanate level is maintained at from 7 to 12 mg. per cent, favorable results may be obtained. If the level is higher, toxic effects may be experienced, while effective response is not usually forthcoming if the level is below 7 mg. per cent. Since Barker's work, many reports[24, 25, 26] have been published on the subject.

A general review of these articles shows that the results obtained follow a certain well-defined general pattern. The doses used have been about 1½ grains three or four times a day, which results in the optimal level of 8 to 12 mg. per cent in the blood. In most instances, patients have been carefully selected. Older people with marked arteriosclerosis have been excluded, as well as patients with renal insufficiency, advanced heart failure and malignant hypertension. About one-half of the patients treated with the thiocyanates show satisfactory improvement. Of the other half classed as unsatisfactory, approximately one-fourth obtained no relief while the remaining one-fourth

may be said to have been made worse in one way or another.

Personal experiences with the thiocyanates at the hospital and in office practice antedates Barker's revival. Approximately one-third of the patients so treated have had a distinct drop in blood pressure and were benefited clinically. In about 40 per cent of the patients, the treatment seems to have no advantage nor great disadvantage, but it was unsuccessful. Of the remaining cases, 15 per cent obtained symptomatic relief without a marked drop of blood pressure, and the other 15 per cent were made worse and treatment was discontinued.

Surgical treatment.—In the light of modern research work of Goldblatt[27], the so-called surgical kidney has assumed more importance than ever before. There is no doubt that in some instances a unilateral kidney disease is responsible for the hypertension, and removal of the diseased kidney for its cure. Nevertheless, there is truth in the observation made by some that essential hypertension is so common that the coincidence of hypertension and renal lesions of a surgical nature is apt to occur in a certain percentage of cases. When an individual has hypertension and a surgical lesion of the kidney, a number of factors must be considered before the patient is subjected to a surgical operation for cure of hypertension. For example: (1) Is there sufficient evidence from the history and examinations that the high blood pressure is influenced by the renal lesion? (2) Will the patient progress satisfactorily if no surgery is done? (3) Is the patient's condition satisfactory for an operation? (4) Does the opposite kidney function adequately?

Operative measures have been employed for reducing essential hypertension by either section of the anterior spinal roots from the sixth thoracic to the second lumbar nerves, or section of the major and minor splanchnic nerves. These operations aim at increasing the renal blood supply. They originated in the United States by Adson[28], Peet[29] and Heuer[30], but have not been as successful as was first hoped for. These surgical procedures are merely palliative as are the usual medical measures. They do not alter the fundamental factors concerned with causing high blood pressure. As pointed out by Adson[31], the clinical symptoms invariably disappear with reduction of blood pressure, but in a number of instances the patient continues to be free from symptoms even though the increased blood pressure returns. Neurosurgeons believe that it is necessary to select patients in the earlier stages of hypertension before sclerosis of the arterioles develops. Patients with essential hypertension may have the benign or the malignant types. The patient with benign or red hypertension is usually in good health, in contrast to the pale livid hypertensive patient who is the candidate for an early malignant phase. Surgery is not indicated if the malignant phase has set in.

If hypertension is associated with heart failure, renal failure or evidence of cerebral damage, these operations are contraindicated. If a patient has a severe form of hypertension, one with a high inflexible diastolic pressure which barely responds to sedatives, and if retinal features of malignant hypertension have set in, surgery is usually fruitless. Patients with the simple benign type are hardly candidates for sympathectomies. Benign hypertension runs an uncertain course; many patients live for years without a decided decline in health and attain a ripe old age without much distress from the high blood pressure.

Authorities agree that a limited number of patients may benefit from the operation. They are those under 50 years of age with a very high blood pressure who have general vasoconstriction, and yet the signs of malignant hypertension have not fully developed. Providing a satisfactory vasodilatation is secured by sedatives, the operation is indicated. The practice of some neurosurgeons to advise splanchnicotomy in individuals with benign hypertension as a step to forestall the ultimate breakdown is questionable because the course that benign hypertension may take is usually unpredictable and the benefits of surgery have not been any more satisfactory than those from medical measures. If the majority or even a large number of the benign cases became malignant, there would be no question of approval.

Surgeons summarize the situation when they say that until an anti-pressor substance is developed which is successful, surgery offers the only sure method of relief for a large group of hypertensive patients. This is acceptable providing symptoms are severe enough to require relief or if evidence suggests that the hypertensive disease is making rapid progress. It must be emphasized that most hypertensive persons remain symptomless for years and that the condition runs a benign course. After all, surgery is merely palliative, not curative, since it does not alter the fundamental cause.

Renal extracts.—Such striking results have been reported by some research workers on the use of kidney extracts in the treatment of hypertension that the problem has evoked wide interest. A crucial fact stands out prominently, and that is, a normal kidney produces or does something to reduce hypertension provoked by interference with the blood supply of the opposite one. Attempts to extract this unknown depressor substance by different investigators are now in progress. The nature of the anti-pressor substance that appears to be present in kidneys is undetermined and its mode of action has not been clearly worked out.

Our interest was aroused when Page made his early reports on the use of kidney extract. We began to make the kidney extract according to the formula given to us by Dr. Page. Before the kidney extract is used for clinical work, it is cultured for six days and tried out on rats made hypertensive. The extract is given intramuscularly, 5 to 10 cc. every day or two, depending upon the individual responses. One cc. is equivalent to 175 Gm. of pork kidney, and the average dose per day per patient ranges from 700 to 1,500 Gm. of kidney.

Our experiences with kidney extract may be summarized as follows:

1. Only patients with severe benign hypertension and early malignant hypertension have been used, and carefully controlled pretreatment periods have been established.

2. In some instances, painful local reactions develop which make the use of the material unacceptable. The general reactions have been of two kinds: (a) the anaphylactic reactions, which are aggravating but not dangerous, and which may be controlled by the use of histaminase, adrenalin and papaverine. (b) Another kind of reaction which is more alarming is the one that is apparently the result of the inhibitor or anti-pressor substance, which causes an abrupt fall in the blood pressure with a shock-like syndrome. These are controlled with epinephrine and ephedrine, intravenous glucose solutions and stimulants.

3. Twelve patients have been treated; 8 have been considered as showing satisfactory results, 2 failed to respond, and 2 were discouraged and quit voluntarily because of unpleasant reactions.

4. No permanent injury has been sustained by any patient. All are either better from treatment or at least the same as before they started. None was made worse.

5. Sometimes patients have been decidedly improved symptomatically, but the drop of blood pressure was not correspondingly great.

6. Obviously it is premature to make any sweeping conclusions about the value of these kidney extracts, but the results in some cases have been so dramatic that it is difficult to suppress undue enthusiasm. The best results have occurred in patients with the severest kind of blood pressure. The work with kidney extracts has been of an investigative nature and naturally many changes will be made before a finished product is available. From our observations, there is little doubt that in the kidney there is an anti-pressor or some depressor substance which will reduce high blood pressure, and that the answer to the problem of cure of hypertension lies in the kidney and most likely in kidney extracts.

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Nasal Therapy in the Common Cold*

By THEODORE WALSH, M. D.**
St. Louis, Missouri

IN ORDER to make clear the rationale of nasal therapy of the common cold, I will discuss briefly the etiology of this condition and also review the normal defenses of the nose against infection.

I think it is generally agreed that the symptoms of the disease entity "common cold" and of its complications are caused by one or more of the pathogenic bacteria associated with respiratory disease. These organisms, like the poor, are always with us. Under ideal conditions, the nose has adequate defense against their invasion, the first lines of defense consisting of the ciliated epithelium which lines the upper respiratory tract and the blanket of mucus which overlies the epithelium. It is when the continuity of the mucus is broken and when the cilia cease to function normally that pathogenic micro-organisms are able to come in contact with and penetrate the epithelium, reach the subepithelial tissues, and give rise to disease. The second line of defense against infection is the normal immune response of the body. There are many individuals who never take cold, in spite of apparently unhealthy modes of living, whereas others take cold at the slightest provocation. The difference lies in their natural immune reactions.

The factors that tend to break down the first line of defense may be classified as physical, metabolic, and biologic.

Physical

Anyone who has observed living cilia under the microscope has been impressed with the effect of drying on their activity. Unless cilia are kept constantly moist they soon cease to beat and can be resuscitated only with difficulty. Proetz,[1] Hilding[2] and others have observed and reported the effects of temperature changes on the activity of the cilia. They found that cilia beat effectively at between 18 and 33 C., that at 40 C. motion is greatly retarded and ceases at between 43 and 44 C. The effect of hot, dry atmospheres and of anatomic abnormalities which cause drying of the mucosa by deflection of air currents are therefore predisposing factors in the production of colds.

Metabolic

There can be little doubt that factors which alter the normal metabolic processes of the body affect the membranes of the upper respiratory tract, either by alteration in the activity of the cilia and the production of mucus or in the immunologic response of the membrane. Fatigue, chilling, exposure, overindulgence in food or drink, dietary insufficiencies and glandular disturbances all have their effects. Probably all of us have experienced the nasal congestion that follows too heavy a meal or the assimilation of alcoholic drinks. Rhinologists are familiar with the alteration in the nasal mucosa in thyroid diseases and in women at the menstrual period. These factors impair the efficiency of the nasal defenses and permit infection of the subepithelial tissues by pathogens that may reach the nose at such times.

Biologic

There can be no doubt that a filter-passing virus is responsible for the initiation of the common cold in a certain percentage of cases. Kruse,[3] Foster,[4] Dochez[5] and his coworkers and Long[6] and his associates have all transmitted colds to normal individuals by the intranasal inoculation of filtered washings from the nasopharynx of others with acute colds. These workers were successful in their transmissions in about 40 to 60 per cent of cases. The patients under observation were kept in strict isolation with no chance of secondary infection from the outside world. In such patients there was no significant change in the flora of the nose

* Presented at the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.
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during the course of the colds initiated by the virus. The colds were of short duration, uncomplicated and self-limiting. The chief clinical symptoms were stuffiness of the nose and sneezing. In several cases it was noted that there was an exacerbation of the cold when the individual was freed from quarantine after apparent recovery from the experimental cold.

Therefore, it would seem that the virus prepares the ground for the secondary invaders. The acute rhinitis caused by the virus itself is over in twenty-four to forty-eight hours.

Stages of Infection

The stages of infection therefore may be described as:

1. *Prodromal,* in which the first defenses are broken down and the patient feels that sense of drying and discomfort in the nasopharynx which is so frequently present before the acute rhinitis starts. Under the title of prodromal I believe I would also place the symptoms which accompany virus infections, namely, acute rhinorrhea, sneezing and nasal obstruction. The prodromal stage is followed by the

2. *Acute Stage,* when the secondary invaders have become active. This is characterized by sneezing, nasal obstruction, diffuse watery discharge and malaise and gives place in a few days (this varies in the individual) to the

3. *Subacute Stage,* in which the character of the discharge changes from a watery mucus to a thick mucopurulent secretion. In the subacute stage the engorgement of the vessels and the edema and swelling of the mucosa gradually subside and the nose becomes less obstructed by swelling but perhaps more obstructed by the thick sticky secretions. Lastly, there is the

4. *Stage of Resolution,* in which gradually the discharge ceases and the nose returns to normal or, in the more unfavorable cases, the infection becomes chronic.

Therapy

When we consider therapy we must be aware of the changes which occur in the mucosa in the various stages of the cold. The objective of any therapy should be to return the mucous membrane to a physiologic state.

In the prodromal stage, the membrane is still, for the most part, normal. There is local irritation if drying has occurred or if crusting is present. There is some hypersecretion of the glands when the virus has attacked. The object of treatment in this stage is to supply moisture and to stimulate ciliary activity. Both can be accomplished by the use of a vasoconstrictor drug in normal saline or perhaps by moistening the atmosphere as by a steam kettle. If such measures are instituted early, not infrequently a "cold" may be aborted.

In the acute stage, the membrane has become swollen and edematous. The mucous glands are hyperactive in an attempt to wash out invading organisms; there is vasodilatation and a beginning diapedesis of leukocytes into the subepithelial tissues. At this stage organisms have entered the subepithelial tissues and are waging an active battle with the leukocytes which are the shock troops of the body in acute infection. Any manipulation which will jeopardize the chances of the leukocytes or which will open further portals to the invading organisms is to be avoided. Therefore a regimen of "hands off" is to be recommended. However, the patient needs rest, fluids and warmth. Rest is impossible in the presence of the acute discomfort of nasal obstruction. Therefore, mild vasoconstrictors in normal saline are indicated locally. Sedatives are in order. Fluids should be forced and steam inhalations will help the embarrassed mucosa. Ephedrine with nembutal capsules at night provide vasoconstriction and sedation and are of value.

In the subacute stage and stage of resolution, the battle between the organisms and the white cells is partially over. Dead cells and organisms mixed with mucus are being excreted from the membrane. The acute stage is over and healing has started. The cilia are working hard to remove the debris. There may be an accumulation of debris in the sinuses. Mechanical aid may now be necessary to help the membrane, and we have no fear of trauma because the second line of defense is mobilized against the

invader. Therefore, washing of the nose and sinuses with physiologic saline solution, shrinkage of the nasal tissues to improve ventilation and promote comfort, and suction with a fine canula are useful procedures. Displacement therapy, as described by Proetz,[7] is recommended. If this is not successful, washing of the antrum either via the normal ostium or through a puncture in the inferior meatus may be done; however, it is important to avoid mechanical washing or displacement in the acute stage.

Nasal Medications

I have spoken of "mild vasoconstrictors" for use in the nose. The question arises as to what drugs are best suited for nasal therapy. When considering drugs for nasal use it is important that we should ask ourselves these questions:

1. Does the drug do what I want it to?
2. If so, does it do this without harming the nasal tissues?
3. If it fulfills both of the above, does it do harm elsewhere in the body?

Let us consider the drugs commonly used in the nose in the light of these criteria. To start with the vehicle,—mineral oil is a common vehicle for nasal medicaments. Although it does no chemical harm to cilia, it does cause them embarrassment because of its inability to mix with mucus. Oil lies inert on top of the mucous blanket and its added weight gives the cilia more work to do. Further, because it mixes poorly with mucus any drug dissolved in oil reaches the epithelium slowly. Third, the very real danger of aspiration of nasal medication should be a warning against using mineral oil in the nose for fear of producing lipoid pneumonia. This applies specially to infants and the aged. Watery solutions should be isotonic. Hypotonic or hypertonic solutions cause destruction of cilia.

The vasoconstrictors commonly used are epinephrine, ephedrine and neosynephrin, other preparations of like sort, and benzedrine. Epinephrine causes almost immediate cessation of ciliary function. Although it does cause quick and complete vasoconstriction, its effect lasts but a short time and is followed by a period of vasodilatation which may be prolonged. Ephedrine and neosynephrin, on the other hand, stimulate cilia to increased activity and although their vasoconstrictive action is slower than that of epinephrine, it lasts longer and is not followed by a phase of vasodilatation. Benzedrine does no harm to cilia. It is, however, a severe central nervous stimulant and if used should be used cautiously.

Antiseptics are frequently recommended for use in the nose. I have yet to find a substance that will kill bacteria without also ruining the nasal mucosa.

It is claimed that the silver preparations are nonirritative, nontoxic and antiseptic. I found that organisms mixed with the 10 per cent solution of the common colloidal silver preparations were viable after forty-four hours at room temperature. These preparations, although they do no chemical injury to cilia, do precipitate and cause ciliary clogging. Further, if they are aspirated they cause considerable damage to lung tissue. I can find very little excuse for their use.

Prophylaxis

Any discussion of the therapy of colds would be incomplete without some mention of prophylaxis. For years vaccines of the common respiratory pathogens have been administered subcutaneously or orally in an endeavor to enhance the immune responses of the body against respiratory pathogens. That the results have not been satisfactory is seen by examining the literature on the subject. In large and well controlled series of cases in which vaccines have been used, the incidence of colds in the vaccinated group differed slightly, if at all, from that in the control group. There is no time here to enumerate the contributions on the subject, but they are summarized by Diehl[8] in his experiments at the University of Minnesota, the results of which were published in the *Journal of the American Medical Association* in 1938.

In considering wherein lies the failure of such vaccinations one is led to conclude either that the respiratory organisms are, on the whole, poor antigens or that if they produce antibodies adequately these antibodies are not present in sufficient concentration in

the vulnerable nasal tissues to be effective. It is well known that the ideal conditions of tissue immunity are those in which there are in the tissues both mobilized phagocytes and specific antibodies. These conditions may be obtained in the skin following the local injection of vaccine. The question arose whether they would also obtain in the nose following the application of vaccine to the nasal mucosa.

In an endeavor to investigate this question, Dr. Paul Cannon,[9] with whom I had the privilege and pleasure of working in Chicago, and I applied vaccine to the nasal mucosa of rabbits by dropping it into the nose using a tuberculin syringe without a needle and taking care that no trauma was inflicted. After varying periods of vaccination and at different intervals between vaccination and death, we removed the nasal mucosa, spleen, lungs and other tissues from the rabbit together with blood serum, extracted these tissues with saline, and set up agglutination titrations against the homologous organism. We found that following local vaccination the antibody titer of the nasal mucosa was constantly higher than that of the spleen, liver and other tissues. It was frequently as high, and occasionally higher, than that of the serum.

On the other hand, when we immunized rabbits with the same vaccine by subcutaneous injection the antibody titer of the nasal mucosa was seldom as high as that of the spleen and was always lower than that of the blood serum. We found further that the antibody produced was entirely specific so that, for example, if Bact. typhosum was used as the antigen there was no cross agglutination with Bact. paratyphosum B. and vice versa. We also found in microscopic sections of such vaccinated nasal tissues that there was a subepithelial accumulation of macrophages and lymphocytes which was not present in the animals which were vaccinated subcutaneously. In examining the re-

Table 1

Agglutinin Titers of Tissues and Blood Serum of Rabbits Immunized Intranasally Against Bact. Paratyphosum B. Following Nonspecific Stimulation of Nasal Mucosa With Solution of Formaldehyde (1:333)

Animal	Days of Formaldehyde	Days of Vaccination	Day of Death	Blood Serum	Nasal Mucosa	Spleen	Lung	Liver
25	1	4	4	120	480	0	0	0
26	1	4	4	240	480	0	0	0
27	1	4	5	240	480	0	0	0
28	1	4	5	0	0	0	0	0
29	1	4	6	0	0	0	0	0
30	1	4	6	480	240	0	240	0
62	1	4	5	480	0	0	0	0
63	1	5	6	960	240	120	480	0
41	3	7	4	120	240	0	240	0
40	3	8	4	480	240	0	0	0
39	3	3	4	480	120	0	0	0
38	3	9	4	960	960	0	240	0
37	3	9	4	960	240	0	0	120

Table 2

Agglutinin Titers* of Tissues and Blood Serum of Rabbits Immunized Against Bact. Paratyphosum B. by Subcutaneous Injection of Vaccine

Animal	Blood Serum	Nasal Mucosa	Spleen	Lung	Liver
21	960	0	240	0	120
22	960	0	240	0	0
71	1,920	0	120	240	120
72	1,920	480	240	480	120

*Titrations were not taken above 1:1,920.

sults of such vaccinations, both subcutaneous and local, we found that the ratio of tissue antibodies to serum antibodies was on an average one to ten for parenterally administered vaccine, whereas when the antigen was administered locally the ratio on the average was one to five. The specificity of the reaction led to a further experiment which was done to determine whether antibodies are actually formed locally or accumulate in the tissue because of inflammatory reactions. In this experiment we vaccinated rabbits by two methods with two antigens and at the same time. We used Bact. paratyphosum B. locally in the nose and typhosum by intraperitoneal injection. After appropriate times of vaccination, the tissues and serum were extracted and agglutination titrations against both antigens determined.

It is seen from Table 3 that where the blood serum titer of the two antigens is the same the titer in the mucosa for the locally applied antigens is many times higher than that for antigen administered parenterally. It seemed reasonable to conclude from such experiments that there is a local formation of antibody and at the same time a mobilization of phagocytes in the tissues, the ideal condition for tissue immunity. It followed, therefore, that if any protection against colds by the use of vaccine was to be hoped for, the rational method of immunization was by application of vaccine to the nasal mucosa. To this end we prepared polyvalent

Table 3

Agglutinin Titers of Tissues and Serum of Animals Vaccinated Simultaneously With Two Antigens, One by Intraperitoneal Injection, the Other by Intranasal Application

Animal	Antigen	Blood Serum	Nasal Mucosa	Lung	Spleen	Intestine
56	Gen.	960	30	30	240	0
	Loc.	120	30	30	0	0
59	Gen.	1920	240	60	480	0
	Loc.	240	240	0	30	0
60	Gen.	960	30	120	480	0
	Loc.	960	120	240	60	0
61	Gen.	3840	240	240	480	120
	Loc.	480	240	240	60	0
62	Gen.	1920	120	120	120	60
	Loc.	240	120	120	0	0
67	Gen.	960	60	120	120	60
	Loc.	480	480	480	30	0
68	Gen.	960	120	120	120	0
	Loc.	960	240	480	30	0
70	Gen.	960	30	30	120	0
	Loc.	960	240	480	60	30

Table 4

Year	No. of Patients	Good, Per Cent	Fair, Per Cent	Combined, Per Cent	Bad, Per Cent
1932–33	24	19–79	1– 4	20–83	4–17
1933–34	66	45–68	8–12	53–80	13–20
1934–35	79	63–80	8–10	71–90	8–10
1935–36	100	76–76	12–12	88–88	12–12
1936–37	108	80–74	13–12	93–86	15–14
1937–38	101	78–77	7– 7	85–84	16–16
1938–39	90	65–72	10–11	75–83	15–17
1939–40	59	38–66	6–10	44–75	15–24
Total	627	464–74	65–10	529–84	98–16

formalin killed vaccines from cultures taken in the ear, nose and throat clinic. The vaccine contained many strains of all the common respiratory pathogens.

Patients who complained of frequent colds were treated by spraying the vaccine into the nose each night during the cold season. For our results we established the following criteria. If patients had no colds or perhaps one mild cold lasting not more than forty-eight hours, the result was said to be "good." More than two attacks of rhinitis, even though of short duration, and not more than three such attacks constituted a "fair" result. More than two mild colds or even one severe cold in spite of the patient's protestations of improvement was labelled a "bad" result. The results on the basis of these criteria are seen in Table 4.

Summary

To summarize, therefore, colds occur when the normal defenses of the nose are broken down permitting invading respiratory bacteria to enter the nasal tissues. Colds have three main stages, and the therapy we institute has as its objective a return of the nasal tissues to a physiologic state. The medications we use locally in the nose should be examined in the light of criteria mentioned above, and therapy should be undertaken with an understanding of the pathologic changes present in the nose in the various stages of a cold. There is ample experimental evidence to show why parenteral injections of vaccine are unlikely to be effective as a prophylactic measure, and why vaccination by local application is preferable. Clinical results so far seem to warrant the further trial of vaccination by intranasal spray.

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Management of the Premature Infant

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THIS paper seeks to discuss the management of the premature infant. Methods and conclusions are based primarily on data obtained from the observation of 622 prematures, born and treated at the Milwaukee County Hospital between January 1, 1937, and August 1, 1940. Before entering into the discussion itself, however, it may be well to review the fundamentals of definition and of symptomatology with regard to prematurity.

Definition

As a result of widespread study of prematurity, we have formed a more clear-cut conception of its meaning. As a general rule, any baby which at birth weighs less than 5½ pounds (2,500 Gm.) should be regarded as premature. There is some argument remaining on what constitutes prematurity, but opinions differ only to a minor extent. In an effort to establish a standard for prematurity, the British Pediatric Association and the Section on Diseases of Children of the Royal Society of Medicine appointed a committee composed chiefly of pediatricians, who suggested the standard of 5½ pounds weight or under as a criterion of prematurity. This committee then contacted the Royal College of Physicians and the British College of Obstetricians and Gynecologists and found that neither group was satisfied. No constructive reason for their dissatisfaction was offered, so the original committee adopted a resolution to the effect that "in conformity with the standard in international use, an infant whose birth weight is 5½ pounds (2,500 Gm.) or less shall be considered for the purpose of comparison of records as either immature or prematurely born, according to whether the estimated period of gestation is full time or less."

American observers have accepted this description of premature infants in so far as the weight is concerned, but believe that the length of the baby should likewise be given consideration. As a consequence, they add that any baby measuring less than 45 cm. (17.7 inches) should also be regarded as premature.

Physical Appearance

The characteristics by which we recognize the premature infant necessarily vary greatly,[1] depending upon the term of the intra-uterine life. As a rule, he is small and has a thin face full of wrinkles, which is less pronounced as he approaches the full term. The head, more especially in small prematures, appears out of proportion when compared to the small trunk and short extremities. The skin is soft and usually of a red or more or less cyanotic appearance. It is usually thin enough for the blood vessels to be seen easily, especially on the head and scalp. There is a marked deficiency of adipose tissue. The lanugo, or fine hair, is plentiful, particularly upon the upper part of the face and the extensor surfaces of the extremities. The ears are soft and small and contain little cartilage. In comparison with the dolichocephalic skull of the normal newborn, the premature infant has a round or ovoid shaped skull. The nails vary according to the fetal age, and in early prematures there may be very little evidence of them. The cry is weak and sometimes barely audible. The neck is short and the trunk blends into a very distended abdomen. There is usually a hernia at the umbilicus. The legs are short and often bowed, simulating a perpetuation of their intra-uterine position.

Causes of Premature Delivery

Duyzings,[2] of the Netherlands, in a study of 1,926 prematures, divides the causes of premature birth into three groups: (1) Unknown, (2) a result of disease of the mother, and (3) abnormalities of the fetus or placenta.

He reported that in at least one-third of the total number of premature deliveries, namely 549 cases, no anatomic causes could be detected clinically. The ages of mothers,

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number of deliveries, marital conditions and occupations were tabulated. Many young, unmarried primiparae, who had a profession, were found in this group. Duyzings found that the prospect of a premature delivery diminishes with increasing age of the mother, except after 35 years of age, when the probability of a premature delivery is much increased again. The prospect of a premature delivery is greater in primiparae than in multiparae. The marital condition apparently plays no role, as premature deliveries were found in 7.6 per cent of married mothers and in 7.1 per cent of unmarried mothers. The percentage of premature deliveries was not higher in domestic help than in married women who attended to their household.

In the second group of premature deliveries, the following diseases of the mother were found: syphilis, chronic nephritis, premature separation of placenta, toxicosis of pregnancy, eclampsia, pyelitis, pulmonary diseases, and lesions of the central nervous system.

In the third group of premature deliveries, the following conditions were found: placenta previa, twins, hemorrhages during pregnancy without known cause, developmental disturbances, habitual premature delivery, premature rupture of the sac, hydrorrhea amniotica, and hydramnion. Elderly married multiparae predominated in this group, the histories revealing premature deliveries in not less than 23 per cent of all multiparae. Fourteen per cent gave a history of having had one premature delivery.

In the group of premature deliveries without cause, 23 per cent of the multiparae gave a history of having had such a delivery. Apparently a constitutional factor plays a role here. Fertility of women who have an inclination to premature deliveries is relatively small. This is probably also due to a constitutional factor.

Causes of Death in Stillborn and Premature

Duyzings gives the causes of death in stillborn as follows: (1) Premature delivery, (2) trauma intra partum, and (3) diseases of the mother. The causes of death of those born prematurely were: (1) Premature delivery, (2) gastro-intestinal disorders, and (3) infections of the respiratory tract.

Among the causes of death in the first four months, premature delivery and gastro-intestinal disturbances predominated, while later on respiratory disease occupied the first place. Convulsions and jaundice were not infrequent causes of death. Duyzings questions the importance of cerebral hemorrhage as a frequent cause of death of premature infants. The prospect of remaining alive increases with the duration of pregnancy and with the weight of the newborn. The smallest newborn who remained alive weighed 1,240 Gm. The mortality was higher in the male sex than in the female. Mental diseases were found at the check-up in 7.6 per cent of premature infants.

There are, in my experience, three primary causes of death in prematures: (1) Infection, (2) improper feeding, and (3) variations in temperature. The clinic, therefore, must combat and correct these causes, and to do this the following routine has been inaugurated at the Milwaukee County Hospital.

Infection.—An admission bath may or may not be given immediately after birth, depending upon the condition of the baby. In this bath green soap and warm running water are used. This is followed with a 5 per cent ammoniated mercury inunction. Thereafter a daily bath, using a 50 per cent glycerine solution is given unless contraindicated by the condition of the baby. At all times special precautions are taken to avoid unnecessary exposure of the infant. These prematures are cared for in the Newborn Nursery at the Hospital, each child being placed either in a Hess bed or a cubicle. Any infection is combated by transfusion and oxygen.

Feeding.—Before the infant starts on milk feedings, meconium should have been passed or should have been removed by a normal saline flushing. Then the following steps in establishing a feeding schedule should be taken: (1) Feedings of milk should be withheld for the first ten to twelve hours. (2) After twelve hours, 4 cc. of full strength breast milk should be given. This should be increased 1 cc. at each feeding at four hour

intervals, except that after regurgitation no increase is made. (3) After the first twenty-four hours, water should be given between feedings if possible. (4) After twenty-four hours, 10 drops of Spirits of Frumenti should be added to each feeding. (5) After twenty-four hours, the infant should have feedings every two hours during the day, and every three hours during the night, or ten feedings in twenty-four hours. As soon as possible, a three hour schedule should be adopted for the whole twenty-four hour period.

Under this schedule an average daily gain of from ⅓ to ⅔ ounces may be considered satisfactory. All premature infants should, of course, be weighed in a blanket. Babies 3 pounds or less at birth are weighed once a week; 3 to 4 pounds, every third day; 4 to 5 pounds, every other day; over 5 pounds, every day.

Four methods of feeding are employed: (1) Medicine dropper, (2) gavage, (3) Breck feeder, and (4) bottle. All prematures are given their first feedings by means of a medicine dropper, which has rubber tubing fitted to it to extend ¼ inch from its end.

When breast milk* is not available our standard formula is used, namely, one part evaporated milk and two parts water. All premature feedings are fortified with 4 per cent Knox gelatin which we have found to give an added stimulus to weight and growth. In special cases, Reticulogen (liver extract) has been employed. In the first seven months of 1940, 11 babies were treated with it, and it was noted that those infants who appeared almost entirely inadequate for life gave a good response under treatment. Furthermore, interest centered in observing whether Reticulogen produced a firmer red blood cell count in these infants, but sufficient data to determine this point are not yet available.

Temperature.—The temperature is taken every four hours until the baby reaches 5½ pounds and ceases to be premature. The temperature is maintained by hot beds or by a Hess incubator. The clothing consists of a band with cord dressing, a diaper, and a shirt. The infant is wrapped in a blanket with a diaper under his head.

General.—Carbon dioxide and oxygen are given for the first few days or as long as necessary. This is usually given through a funnel, special precautions being taken to keep the funnel clean, and to see that it is changed daily. Prematures are discharged when they weigh between 5½ and 6 pounds, but not until home conditions, into which the baby will be received, have been checked by a county nurse. The latter also sees the baby in his home once or twice following discharge. The further development of the baby is then followed at the Baby Clinic in the Milwaukee County Hospital.

Results

Under this method of hospital care, the following results were noted: During the years 1937 through 1938 and during the first seven months of 1940, 648 prematures (622, not counting the home deliveries) were born at the Milwaukee County Hospital. Of the 622 infants, 86 were stillborn and 44 were nonviable. Of the remaining 492 who could be subjected to the care outlined, 46 or 9.3 per cent died within the first twenty-four hours. Of the 446 to outlive the first twenty-four hours, only 30 or 6.7 per cent died. The total fatalities of all those treated, exclusive of stillborn and nonviable, were 76 or 15.4 per cent.

In conclusion, I will quote from Dr. S. F. Morgan's "Conduct of the Newborn Nursery" as relating to Columbia Hospital, Milwaukee:

> "Results such as these do not, however, depend entirely upon the method of hospital care here discussed. Most important, we believe, is the development of a truly cooperative spirit, in addition to rigid technic, which unites house staff, nurses and physicians, and which is carried out in such a friendly way, with as little haranguing as possible, that parents and relatives gladly share in the protection of their own babies as well as others."

* It is interesting to note that 15,158 ounces of breast milk were collected from mothers in the hospital and from mothers already discharged during the first six months of 1940, which milk was pooled and boiled. This gave us a splendid supply and also enabled us to furnish breast milk to institutions other than our own.

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Some Practical Aspects of Chronic Suppurative Otitis Media*

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THIS paper presents an analysis of the pathology and therapy of 72 cases of chronic otitis media followed at Milwaukee County Hospital during the last two years.

Chronic suppurative otitis media may be defined as middle ear suppuration of more than eight weeks' duration. As with most generalities, this arbitrary classification does not hold true in many cases. Many an acute otitis media clears up after two months, and conversely, many an otitis media may be considered chronic from its onset, because of the marked bone destruction which occurs early in the disease. Good examples of this type may be found in those cases occurring in conjunction with the acute exanthemata, particularly scarlet fever. However, from the standpoint of setting a line of departure for this discussion, we will consider an acute otitis media as having become chronic after two months.

The pathology of this disease may be divided, for practical purposes, into three main types: (1) The soft tissue type, (2) the osteitic type and (3) the cholesteatomatous type.

The soft tissue type consists of chronic inflammatory change in the mucosa of the middle ear, with very little change in the bony structure in, and contiguous to, the middle ear. This type is most commonly associated with obstruction to the eustachian tube or to nasopharyngeal infection which continuously feeds bacteria through the tube into the middle ear. This nasopharyngeal suppuration may be secondary to infection in the paranasal sinuses, particularly the posterior ethmoids and sphenoids, or it may be due directly to bacteria lodged in the lymphoid tissue in this area, especially around the eustachian tube orifices. This type of aural infection is a relatively benign form and is more amenable to conservative treatment and, as a matter of fact, less amenable to radical surgery than any other type of chronic middle ear infection.

It manifests itself clinically by a central perforation in the ear drum with a mucoid or mucopurulent discharge and, as a rule, there is very little hearing loss.

The osteitic type has as its basic pathology an infectious bone destroying lesion involving any of the following structures: the ossicles, the bony walls of the middle ear including the annulus tympanicus, the mastoid antrum, and the mastoid process itself. If the infection is low grade, as most of them are, there will gradually be a replacement of the mastoid cells with a dense eburnated type of bone which is seen characteristically in the roentgenographic examination of chronic otitis media. This mechanism is disputed by Wittmaack who feels that these cases are merely due to a lack of aeration of the mastoid process in infancy. This is the type of otitis media which frequently accompanies, and is the residual of, the acute exanthemata.

It can be recognized clinically by a marginal perforation in the drum particularly high up in Shrapnell's membrane or the pars flaccida. The discharge may be profuse or meager and always has the foul odor which characterizes bone destroying lesions wherever they occur in the body. There may or may not be granulomatous masses (frequently termed aural polypi) present. The hearing is usually poor. This type of ear is a potentially dangerous one, as the bone destruction may extend through the dural plate or into the labyrinthine capsule.

The third or cholesteatomatous type is characterized by the presence of a peculiar onion skinlike tumor which develops from the desquamation of stratified squamous

* Read at Marquette University School of Medicine, Alumni Association Spring Clinic, May 9, 1941.
** From the Department of Otolaryngology, Marquette University School of Medicine and Milwaukee County Hospital.

epithelium, which has invaded the middle ear from the external auditory canal. These lesions can be recognized clinically by a marginal perforation in the drum (through which it is felt by many that the stratified epithelium invades the middle ear) and by a foul discharge due to the bone necrosis caused by the pressure of the expanding mass on the surrounding bony structures. Smears taken from this discharge will show the presence of cholesterol crystals and desquamated epithelium. The hearing is frequently very poor.

This type of lesion is potentially the most dangerous type of chronic aural suppuration, because the expanding cholesteatomatous mass may easily erode the middle or posterior fossa plates, the labyrinthine capsule, or the canal of the facial nerve.

These pathologic types are not fixed and there are cases which may exhibit any combination of these basic pictures.

Complications

From the standpoint of danger to life, chronic otitis media is important because of its complications. It is, therefore, necessary for the physician to be familiar with the signs of impending complications.

The osteitic or cholesteatomatous types may produce necrosis of the middle or posterior fossa plates causing an extradural abscess. The neurologic findings in cases of this type are usually meager and the only sign, frequently, is a constant, severe, unilateral temporal, parietal or occipital headache. If the disease process is not arrested by adequate surgical attack, a diffuse leptomeningitis or brain abscess may ensue. If the posterior fossa plate is eroded over the lateral sinus, a perisinuous abscess will occur and if a mastoidectomy is not done, a lateral sinus thrombosis may eventuate. Here the warning symptoms may be a severe headache, chills, or a septic temperature curve.

The most common feature of beginning labyrinthine invasion is the presence of a vertigo which is characteristically rotatory in type. Either the patient feels that he is spinning about, or that he is stationary and his environment is rotating. This is accompanied by a nystagmus which is horizontal rotatory in direction, has a fast and slow component, and is of a rapid, usually fine, fibrillating type.

Another important complication manifests itself in a unilateral facial paralysis. This is usually due, in chronic otitis media, to the pressure of a cholesteatoma upon the facial nerve and is a primary indication for immediate radical mastoidectomy.

Treatment

There is no standard treatment for chronic otitis media as is obvious from the diversity of the basic disease. The physician should thoroughly clean the external auditory canal of pus and debris and inspect the entire drum to determine the type and location of the perforation. He should note whether the discharge is mucoid or foul and whether granulations or polypi are present, and where they are attached. Slides of the discharge should be made and studied for the presence of cholesterol crystals and desquamated epithelium. The mastoid should be palpated to elicit possible tenderness or edema. A thorough examination of the nose and paranasal sinuses is in order, and an investigation of the nasopharynx with the nasopharyngoscope, postnasal mirror, or palpating finger, must be done. In cases of marginal perforation or cholesteatoma, radiographic studies are helpful. In complicated cases, tests of labyrinthine function should be made.

It is upon the findings of these examinations that the treatment of any individual case is based. There are, however, certain basic procedures which should be followed. The external auditory canal must be kept clean. This can be accomplished by periodic irrigations of the canal with 35 to 70 per cent alcohol or in some cases by repeated cleansing of the canal by the physician with a cotton wound applicator. Boric, boric iodide, or sulfanilamide powder may be insufflated. Water absolutely must be kept out of the ear.

The nasopharynx must be cleaned of infected or obstructing adenoid tissue and if a sinusitis is present it should be eradicated.

Granulomatous masses should be removed either by a snare or by cautery with silver nitrate, trichloracetic acid, or any other type of chemical cautery. It is well to remember in removing aural polypi with a snare, that they may be attached to the stapes, the middle fossa plate, or the inner wall of the middle ear and care must be taken not to pull off fragments of bone from these structures, lest the patient develop a meningitis or labyrinthitis.

If the patient presents the picture of an intracranial complication or an impending complication, a radical mastoidectomy should be done immediately and all suspected areas thoroughly exposed and explored. A large school of competent otologists feel that radical mastoidectomies should be done in all cases of cholesteatoma, particularly where the hearing is poor.

Review of Cases

I should now like to discuss a series of 72 cases of chronic otitis media treated at the Milwaukee County Hospital during the last two years. These patients received therapy as outlined above. There were, in addition, 250 cases which could not be used for statistical analysis because the patients were seen only once or twice and adequate therapy could not be carried out.

Of the 72 patients, radical mastoidectomies were done on 25. Simple mastoidectomies were done on 7, 2 of whom had subsequent radical surgery. Two patients had revisions of previous radical mastoidectomies. One patient had a modified radical mastoidectomy, and 35 were treated conservatively.

The 25 cases of radical mastoidectomy show the following results: In 22 patients the ears are now dry. In 2 there continues to be a discharge. In 1 patient the ear was dry, but began to discharge again a year later, probably because of recurrent nasopharyngeal disease.

The 7 cases of simple mastoidectomy show the following results: In 2 patients radical mastoidectomies had to be done subsequently, and in both the ears are now dry. In 3 patients the ears are healed, and in 2 they are unimproved.

The 3 patients who had revised radical and modified radical mastoidectomies have recovered.

The 35 patients treated by conservative measures show results as follows: In 17 patients the ears are dry, in 5 they are improved but still discharging, and in 13 they are unimproved.

Comment.—The radical mastoidectomies were done in cases in which complications or symptoms suspicious of impending complications were present and in cases of cholesteatoma. Simple mastoidectomies were done on patients with acute otitis media that persisted after eight weeks, in an attempt to prevent the development of chronic otitis media. Those patients who were treated conservatively had the soft tissue disease outlined above. The relatively poor results obtained in the conservative treatment of these clinic patients should not be accepted as applicable to the results one can obtain in private practice, where a more rigid control of the patient is possible and where instructions are more meticulously followed.

Summary

A resume of the practical aspects of chronic suppurative otitis media is presented, together with the results obtained in the treatment of 72 patients seen at the Milwaukee County Hospital in the last two years.

W. C. Keettel, M. D., Bureau of Maternal and Child Health, State Board of Health, Madison

OBSTETRICAL MANIKIN DEMONSTRATIONS

Throughout each day of the Spring Postgraduate Clinics

Chippewa Falls, April 27—Wausau, April 28—Fond du Lac, April 29

Cardiovascular Disease in Industry

By W. J. EGAN, M. D.
Milwaukee

THE aim of a medical department in an industry is the detection and management of incipient disease, with the purpose of prolonging the lives of the members of the personnel and the reduction in absenteeism from work. Or, as Lanza[1] stated, "The fundamental objective of industrial hygiene is to reduce loss of time, absenteeism and short work spans in industry." Absenteeism from work due to illness is a problem of great magnitude when it is learned that the average annual time loss for each employe in the United States is 9.45 days. Of these, 8.85 days are missed because of non-occupational illness or injury, 0.59 days because of industrial injuries and 0.01 days because of occupational disease. Approximately 2 per cent of all industrial workers are incapacitated all the time because of illness (annual total 400,000,000 days).

It is my purpose to relate to you the results of ten years' experience in the management of a medical department, which was perfectly under our control, and the records of which are quite complete.

Industrial medicine offers a unique opportunity for the control of the health habits of the individual workers. The method of management of a medical department, with the assistance of the managers of the industry, must be carefully planned and explained. It is not only essential to have the confidence of the employe, but it is equally important to work in close harmony with the management. It is necessary to reiterate that the same confidential relationship be maintained between employe and medical department as is maintained in private practice. All records should be kept under lock and key and at no time should patients' records be available to anyone other than a member of the medical department. Each industry can devise its own code with respect to the type of work the employe can do without revelation of the nature of the employe's physical findings. We have used the Bristol[2] classification of employes' condition based upon physical examination (Table 1):

TABLE 1

CLASSIFICATION OF EMPLOYES' CONDITION BASED UPON MEDICAL EXAMINATION

Class A—No Physical Defects

Employes will be put in this classification who have no physical impairments which would in any way affect their attendance or impair their working efficiency (Example—Class A).

Class B–1 — Minor Physical Defects — Correction Advised

This classification will be used in cases where employes are suitable for employment, but where there is a minor physical correction that should be made as a help to the employe, but which is not a necessity from the standpoint of the company.

This classification will include a slight defect in vision not sufficiently serious to interfere with work, an undernourished condition in which dieting is advisable, etc. (Example—B–1, teeth).

Class B–2

This classification will be used in a case where the employe's condition is satisfactory for employment, but where there is a correctable defect which the examining physician feels should be cared for sooner or later in order to avoid the possibility of serious trouble, but which it is not necessary to have corrected immediately.

This classification will include such defects as neglected teeth which might result in physical impairments, mild cases of tonsil trouble, etc.

It is expected that employes coming within this classification will have the necessary corrections made after they have had an opportunity to earn sufficient money to enable them to take care of the expense. These cases will be checked by the Medical Department at intervals of about six months to determine whether or not the work has been done (Example—Class B–2, tonsils).

Class B–3—Physical Defects Non-correctable

This classification will be used to indicate that the employe has certain deformity, deficiency or weakness which unfits him for certain kinds of work, but not for others (Example—Class B–3, third finger amputated).

Class B–4

This classification will be used to indicate that the employe is not in such physical condition as to be entirely unfit for the work, but has some defect not falling within classes B–1, B–2, or B–3, making him a less desirable employe from a medical standpoint than those coming within the preceding classification but one who might be employed without undue

hazard if a sufficient number of people of better grades cannot readily be secured (Example—Class B–4, slight thyroid enlargement).

Class C—Entirely Unfit or Menace to Others

This classification will be used in cases of employes who have non-correctable impairments of a serious nature, physical defects such as lung conditions which indicate the probability of tuberculosis, serious heart conditions, exophthalmic goiter, etc.

Class D—Classification Deferred

This classification may be used in cases where the employe must be re-examined before being classified. This may be because of such a condition as a fever apparently resulting from a cold or in cases where a correctable impairment exists of such seriousness as to make it advisable to have corrective measures taken before employment (Example—Class D, tonsils to be removed; Class D, fever, re-examined).

The number of visits made during the last ten years average 29,300 a year,—the lowest 24,826 (1932), the highest 32,959 (1938). Our control figures show that an employe averages twenty visits a year to the Medical Department. Table 2 demonstrates the type of monthly report the Medical Department has used for the last eight years.

TABLE 2

REPORT OF MEDICAL DEPARTMENT

Analysis of Absence	*No. Emp. Abs.*	*Days Lost*	*Cum. Days Lost*
A. Minor infection and illness _____			
B. Surgical _____			
C. Medical _____			
D. Neuroses _____			
E. Miscellaneous _____			
F. Accident—duty ____			
G. Accident—off duty__			
Total _____			

Percentage of Lost Time

	This Month	*Years to Date*
Medical _____		
Surgical _____		

Activities of Medical Department—Month of _____

Employes treated	*Total*
Pre-employment examinations _____	
Health surveys _____	
Home calls by physician _____	
Laboratory tests _____	
Home calls by nurse _____	
Patients to physicians' offices _____	
Visits to chiropodist _____	

It is routine in our Department that physical examinations are made before employment, promotion, demotion, dismissal from service, return to work after absence because of illness, when production seems impaired and when requested by department heads or by the employe himself. A sick call is made each morning with extended examinations where indicated. We have found from experience that seeing the employe the first day of illness definitely shortens the number of work days lost.

Table 3 shows the percentage of absenteeism; namely, the number of days lost as compared with the total number of work days of the company.

TABLE 3

PERCENTAGE OF ABSENTEEISM

Year	*Number of Days Lost*	*Per Cent of Time Lost*		
		Total	*Medical*	*Surgical*
1930 _____	10,021	2.2	____	____*
1931 _____	9,576½	2	____	____*
1932 _____	9,710½	2.2	____	____*
1933 _____	6,416½	1.7	1.1	.6
1934 _____	7,291	1.9	1.3	.6
1935 _____	7,234½	1.7	1.2	.5
1936 _____	9,261	1.85	1.35	.5
1937 _____	7,986	1.58	1.03	.55
1938 _____	7,735½	1.54	.98	.56
1939 _____	7,004	1.67	1.21	.46

* Division of absenteeism into medical and surgical classification was not instituted until 1933.

It is evident that the percentage of absenteeism due to surgical causes is rather fixed and that the variation in the figures due to medical causes is due to common colds, influenza, grippe infections, etc.

Table 4 presents the mortality figures per year since 1930. In that period there were 25 male and 13 female deaths. Seven of the male and 5 of the female deaths were due to cardiovascular disease. It appears significant that in a ten year period only one of the deaths was due to tuberculosis.

The prevention and management of cardiovascular disease is approached through three avenues: (1) general, (2) individual or specific, (3) correction of unhealthy plant practices. Under general measures proper classification and suitable placement of the employe, based upon some system of physicomental classification, and bearing in mind at all times individual fatigue factors, is definitely necessary.

TABLE 4

MORTALITY FIGURES PER YEAR

Year	Number of Deaths		Number Due to Cardiovascular Disease	
	Male	*Female*	*Male*	*Female*
1930	0	1	0	0
1931	3	1	0	0
1932	3	1	2	0
1933	1	2	0	1
1934	1	0	0	0
1935	3	1	1	0
1936	6	2	2	0
1937	4	4	0	3
1938	4	1	2	1
1939	0	0	0	0
Total	25	13	7	5

Periodic health examinations are made regularly throughout the year, with electrocardiogram, six foot x-ray cardiac mensuration and blood sedimentation rate studies where indicated. Routine electrocardiograms are made on all persons over the age of 40.

Under specific measures, maintenance of an adequate and proper diet is necessary to avoid malnutrition, obesity, vitamin deficiency or the ingestion of excessive fluids. Vitamin D deficiency has been mentioned as a cause of hydropic degeneration of the myocardium and in scurvy hemorrhage has been noted as a cause of heart muscle degeneration. It is common practice to correct obesity whenever possible for the prevention of cardiac or hypertensive disease. It is well to bear in mind, however, that a fatty heart may occur without obesity. Whether or not obesity predisposes to an effort syndrome is disputable. Early diagnosis, proper management of gout and diabetes may retard the development of atherosclerosis or coronary disease. Vigorous exertion following a heavy meal may precipitate heart failure in auricular fibrillation or coronary disease.

Haggard and Greenberg[3] have reported that daily supplementary feedings decreased the amount of the fatigue, irritability and muscular fatigue, with a distinct decrease in absenteeism among those employes who underwent this experiment.

The effect of tobacco upon the heart seems to depend upon individual tolerance, and in some employes it appears to aggravate coronary disease, angina pectoris, premature contraction or paroxysmal tachycardia. The opinion is becoming more prevalent that tobacco is harmful in peripheral vascular disease, especially in thrombophlebitis obliterans. Moderate use of alcohol does not seem to be a factor in cardiovascular disease.

Because of the similarity of pathologic findings, employes with rheumatic fever, acute or chronic valvular disease are treated in one group.

Pure mitral stenosis, if advanced, with loud diastolic rumbling followed by presystolic reinforcement, by loud accentuation of the pulmonary second sound, and extreme dilatation of the left auricle indicates restriction of activities. If there is only slight presystolic rumbling with little increase in the heart size, work is permissible with frequent re-examination. Such individuals should be directed to administrative, intellectual, or desk work. In the last war we learned that these individuals with mitral or aortic stenosis or insufficiency do not average up well in military work and consequently should follow sedentary occupations.

It is important to distinguish between a true hypertension and a "hypertension deluxe" due to anxiety or dissipation. Employes with a diastolic reading persistently over 85 to 90 millimeters should be examined monthly. Hypertensive patients develop coronary disease, cardiac hypertrophy, dyspnea on exertion, and fatigue readily. Such employes consequently should be placed at easier jobs or jobs with less strain. Employes with well developed hypertension should not be placed in positions where accidents are liable to occur, as their presence in such positions may be dangerous to themselves or others.

A. M. Master, *et al*,[4] reporting studies of 1,440 coronary attacks in 1,077 patients, conclude that occupations and social status do not predispose to coronary occlusion; that coronary occlusion occurs irrespective of the physical activities of the body. They stated that 40 per cent of the attacks occurred while the patients were at rest or asleep, that one-third of the males and practically all of the females were non-smokers and in 375 patients 51 per cent of males and 95 per cent of females were non-drinkers. They could find no evidence that physical effort or excitement produce intimal hemorrhage

in the coronary arteries. Sixty patients who had attacks had been bedridden for weeks or months previous to such attacks.

A. M. Master and S. Dack,[5] speaking of "Rehabilitation Following Acute Coronary Artery Occlusion," stated that three months to one year after the original coronary attack, 62 per cent returned to usual routine of life or work, 14 per cent resumed light to moderate activity, and 8 per cent were completely disabled. One group, those who never completely recovered from the occlusion, were left with a persistent anginal syndrome or evidence of heart failure. The chief cause of failure to return to work was physical disability resulting from angina pectoris, dyspnea or weakness. No employe with coronary disease or anginal symptoms is permitted to work until his blood sedimentation rate is normal.

The institution of a proper syphilis case-finding procedure definitely will decrease the incidence of cardiovascular disease. Early treatment is important in this respect. In Wisconsin the incidence of syphilis determined in premarital examination has been exceedingly low. However, in examinations of 307 applicants for work in an industrial factory, made from August 3, 1939, to August 15, 1940, 14 or over 4 per cent gave positive serologic findings of syphilis. It so happened that these applicants were older than the usual applicants. Employes with late cardiovascular syphilis should not be permitted to work, particularly in heavy industry or in occupations hazardous to themselves, their fellow employes or the public. However, it appears to me that a sensible procedure should be developed to avoid dismissing an employe because of a positive blood reaction. An examination more complete than the usual pre-employment examination should be provided. If no evidence of late damaging cardiovascular or neurologic damage is found these employes should be treated under supervision, and as soon as they are non-infectious they should be allowed to work if treatment is continued faithfully. In cases of advanced syphilis only work of certain limited nature should be permitted.

In 1932 a physical survey for thyrotoxic disease was made of our employes. Those with thyroid disease were taken care of promptly and since that time the Department has been persistently vigilant in the detection of thyrotoxic disease and its cardiovascular complications.

Sydenstricher and Britten,[6] pointed out the remarkable uniformity of mortality when similar ages are used in a study of four groups: (1) agriculture, (2) professions, (3) business, and (4) skilled trades.

Wright[7] stated that 15 per cent of group insurance claims for disability are due to heart disease, and there is little or no difference between the various occupations such as mining, transportation, clerical, steel and other metal workers.

Physical work and exercise do not cause heart disease although they may precipitate or aggravate symptoms and signs of heart disease, and may temporarily exhaust the cardiovascular reserve even in a healthy individual. Much has been written about the "industrial heart," "athletic heart," or "military heart." However, final conclusions are not possible because of insufficient data. In most cases it appears that fatigue or effort syndrome is especially marked in nervous individuals in whom it may amount to a neurocirculatory asthenia.

Two factors are significant in industry where real trauma due to exercise or work directly or indirectly may cause rupture of some part of the heart or great vessels even when the heart is normal. And, secondly, whether or not actual increase in the muscle bulk (hypertrophy) may be harmful has not been determined, as there is no autopsy material upon which to base definite conclusions. Traumatization with or without penetrating wounds of the chest following crushing injuries is much more common than formerly. This is particularly true in cases of accidents in automobiles going at excessive speed, crushing injuries due to heavy machines, or accidents due to electricity. Bear in mind that injuries of all varieties may involve the cardiovascular apparatus in any part—heart, pericardium, great vessels, arteries, or veins.

Coronary disease, chronic valvular disease, luetic aortitis and hypertension are the original disease conditions subject to strain.

The effect of exercise or military strain applies in every detail in industry, especially in older individuals. In industry actual trauma is more of a factor, such as injury in work over machinery, falls, strain of working long hours such as amidst intense heat, especially among older employes who are more liable to degenerative disease. Mixed up in this question is that of the nervous fear of heart disease which can incapacitate one for work just as surely as can organic disease. In cases of neurocirculatory asthenia, cardiac neuroses, early diagnosis with prompt continuous re-education is essential. We have found that a careful physical examination with normal objective findings, which can be demonstrated to the patient, has been of great value in prevention of the development of cardiophobia.

The study of industrial fatigue is an important factor in the prevention of cardiovascular disease. Human fatigue has been defined personally as a state of the human organism in which there is insufficient or lack of balance between intake and output of biologic energy. Fatigue is due to this lack of balance and manifests itself as a deterioration of efficiency, feeling of tiredness and physiologic changes (pulse rate, blood pressure, etc.). It is necessary to recognize the actual existence of industrial fatigue in a worker or in a group of workers. Fatigue is a defense mechanism manifested with various symptoms and signs in varying degrees. The employe may look tired, manifest irritability, yawn frequently, and move slowly; he may present a pallid complexion, heavy eyes, and drooping shoulders. General physical examination may be negative even though he complains of morning tiredness, of not feeling refreshed after a heavy sleep, and of headache and vague pains in some part of the body. It is necessary to distinguish between the industrial and non-industrial factors in these cases. A study of certain factors in an industry may help solve the problem:

1. Labor turnover rates (workers are seeking new jobs)
2. Absenteeism rates (tired)
3. Spoilage (workers careless)
4. Accident rate (workers careless)
5. Frequency and severity of illness (fatigue)
6. Debility and nervous disorder rates (strongly suggest psychogenic fatigue, which may be non-industrial)
7. Output rate (a falling output rate suggests that the worker's task or pace of work may be excessive)

TABLE 5

RECOGNIZED CAUSES OF MARKED FATIGUE

Conditions within the plant:

A. *Physical*
1. Heat, cold, humidity, lighting, improper ventilation, speed or rhythm of work, seating, etc.
2. Hours of work and rest pauses, wage rates, overtime, bonuses, etc.
3. Exposure to low degrees of toxic materials: Cobalt, carbon monoxide, gas fumes, etc.

B. *Emotional*
1. Monotony or variety of work
2. Supervision—discipline
3. Social or group harmony
4. Correct incentives
5. Psychologic fitness

C. *Industrial conditions which operate outside the plant*
1. Adequate nutrition
2. Placement
3. Night work—spread over
4. Distances to and from work
5. Home difficulties

Comments

A report has been made of our experience in management of the personnel of our industry.

It is our belief that we have reduced the rate of mortality of our employes. We know that we have definitely reduced absenteeism from illness.

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A Case of Unilateral Twin Ectopic Pregnancy

By REGINALD W. HAMMOND, M. D.
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Historical Material

IN 1923, Arey,[1] reviewed and reported all cases of unilateral twin ectopic pregnancy. Including 2 of his own, they amounted to 40 authentic cases, 8 questionable, and 4 doubtful.

Falk and Blinick[2] again reviewed the literature in November, 1937, and were able to find 23 additional cases, which with 2 of their own increased the number to 65.

Two years later, Kaplan[3] was unable to find any additional cases reported in the literature, but reported 2 new ones, bringing the number to 67.

Anderson,[4] in Glasgow, reported 1 additional case in 1939.

Browne,[5] in 1940, reported a case of unilateral twin tubal pregnancy, with coincident intra-uterine pregnancy.

Smith[6] reported a case in January, 1941.

Case Report

Upon review of all the available literature, I have been unable to find any additional cases, but I should like to report a case which would then make the number of reported cases 71.

Mrs. A. D. L., aged 32, Para I, married six and a half years, menstruated last March 5, 1941. Beginning April 2, she noticed irregular vaginal bleeding, which continued for about a month. Two weeks prior to her hospital admission on May 15, 1941, she had severe cramplike pains in her lower right abdomen, which would stop after a few hours.

Examination showed her to be a rather pale, thin individual, complaining of abdominal tenderness. The temperature was 99, pulse 100, and respiration 20. Blood pressure was 118/70. Abdominal examination showed a positive Cullen's sign and a tender mass in the lower right abdominal quadrant. Vaginal examination revealed a bloody discharge, a soft cervix with some uterine enlargement, and a tender soft mass continuous with that felt anteriorly.

The urinalysis was normal. Hemoglobin was 70, red blood cell count 4,810,000, and white blood cell count 10,500.

A diagnosis of ectopic pregnancy was made.

Under general anesthesia the abdomen was opened, and this diagnosis was confirmed. There was free bleeding from the enlarged right tube with fresh blood and old clots in the peritoneal cavity. Since the ovary was involved with the tube, both were removed. The left tube and ovary were normal.

The patient made an uneventful recovery, and was discharged from the hospital twelve days later.

Excerpts from the pathologic report: The specimen consisted of a large cystic ovary and a fallopian tube fused to a dark red mass. This mass contained placental tissue and two amniotic cavities separated from each other by a delicate sac. Each contained a straw colored fluid, and an 18 mm. fetus.

Unilateral Twin Ectopic Pregnancy

Summary

A case of unilateral twin ectopic pregnancy has been presented, bringing the total number of reported cases to 71.

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Comments on Treatment

Editor—A. J. QUICK, M. D., Marquette University, Milwaukee

Intra-Bone Marrow Infusion

A new route for the administration of fluids, namely, by way of the bone marrow, has become available through the recent work of Tocantins and O'Neill (Surg., Gynec. and Obst. 73:281, Sept. 1941). For the detailed account of the procedure the original article must be consulted, but a general description of the method is as follows:

A special needle, fitted with an inner needle and a stylet is inserted into the marrow cavity of a bone. The manubrium, or the body of the sternum, is best suited except in the case of small infants. In the latter, one of the long bones, preferably the humerus, tibia or femur should be selected. After entering the marrow cavity, a small amount of blood-marrow mixture (0.1 cc.) is withdrawn. Sterile saline solution should then be alternately injected and aspirated until all the air is displaced by the fluid. The inner needle is then removed and the outer needle connected by means of an adapter and rubber tubing to the buret containing the infusion fluid. The solution is allowed to flow in by gravity, and the rate may vary from 0.4 to 25 cc. per minute.

Bone marrow infusion is essentially the same as the intravenous injection since the absorption into the general circulation is exceedingly rapid and direct. It is therefore the method of choice when veins are difficult to find or to enter. The relative immobility of the needle inserted into a bone has the advantage that fluids can be given to restless patients or in emergency conditions such as in an ambulance, in which the maintenance of a needle in a vein would not be feasible or perhaps possible.

It is obvious that no irritating or hypertonic solution should be given via the bone marrow. At the present stage of development, it seems best to limit the list of fluids to be administered by this route to citrated blood, citrated plasma, serum, 5 per cent glucose, and physiological salt solution. It is logical to conclude that blood given by the intramedulary route is of greater and more prompt benefit than when injected intraperitoneally, especially since absorption is greatly depressed in certain disorders of the gastro-intestinal tract. Parenthetically it might be stated that the value of blood injected intramuscularly is of doubtful value under any circumstance. Large amounts of saline (as much as 2,000 cc.) have been given successfully in shock when general vascular collapse made intravenous administration exceedingly diffiult.

There appear few contraindications for marrow infusion. It should not be used in generalized infection accompanied by bacteremia, since a suppurating process may localize at the site of the injection in the marrow cavity.

In Tocantins' hands the method has been highly successful. In forty patients on whom marrow infusion was carried out, no local or systemic reactions were noted. The author at the outset was aware of the danger of fat emboli from the marrow fat, but points out that the untoward complication is very remote. In none of his patients was there evidence that any significant amount of marrow substance got into the blood stream. The injection of fluid into the marrow causes no demonstrable local damage, and the patient suffers discomfort either during or after the infusion.

The method of marrow infusion is still too new to be fully evaluated, but its potential usefulness should be recognized. Whenever intravenous medication is indicated, but difficulties arise in utilizing this route of administration, the new method via the bone marrow should be considered. It is to be emphasized that the method is not intended to replace intravenous administration, but is a welcome alternative procedure when conditions make the latter difficult or well nigh impossible. A. J. Q.

Vegetables Are Vital

By MRS. MAY REYNOLDS, M. S., Ph. D.
University of Wisconsin, Madison

First of all a teacher, and a qualified research worker as well, Mrs. May Reynolds has been for two decades one of Wisconsin's best-informed nutritionists. By reading, by research, and by continued study she has kept up-to-date on all the latest findings in the field of foods.

Mrs. Reynolds took her undergraduate work at Iowa State College, taught in secondary schools in Iowa, and then came to the University of Wisconsin to teach and to do graduate work for her M. S. and Ph. D. degrees.

She has directed some work on the protein value of canned peas, and at present her research covers other protein utilization studies, conducted on humans by means of nitrogen balance measurements.

She is a member of the research committee of the American Home Economics Association's foods and nutrition section, and a member of the executive committee of the Wisconsin Dietetics Association. She also holds membership in Sigma Xi, national scientific honorary society; Omicron Nu, home economics honorary society; and Sigma Delta Epsilon, national professional society of women in science.

Mrs. Reynolds teaches technical courses in nutrition and dietetics at the University of Wisconsin, and as a scientist who is well aware of the importance of certain protective foods in the diet she writes the following article.

—Francis E. Butler, M. D., Menomonie.

VEGETABLES do the task! In times like these, when America's future depends in a great part on our physical health, vegetables come into prominence as body builders, protectors, and regulators. Vegetables are not a cure-all. They do not supply all the requirements of the human body. But they have a place to fill, and they fill it well. They minister to certain wants which cannot be filled by such other foods as meats, sweets and cereals. They supply an ample share of man's dietary needs.

What are the dietary needs for a healthy body?

First of all, a healthy body must be built upon a healthy framework. That demands quantities of minerals, particularly calcium and phosphorus.

We get most of our calcium from dairy products, and phosphorus usually offers no particular problem, since a good normal diet supplies sufficient phosphorus. But offering some added calcium are such vegetables as cauliflower, lettuce, turnips, carrots and dried beans, and these same vegetables also offer a fair supply of phosphorus.

The body must have materials from which to produce well-formed muscles and organs, and foods rich in proteins are body builders. Here vegetables are weaker than many other foods, but dried peas and beans are a good source of protein, and other vegetables carry small quantities. It must be noted that the protein in these vegetables is not complete, and independently cannot support life and growth, but with other foods, they make a good contribution toward filling the protein needs.

Minerals Keep Uy Body Morale

For healthy bodily organs and for a normal blood stream, minerals are again important. Phosphorus, mentioned earlier, is certainly a necessary nutrient in this respect, and when any deficiency in phosphorus occurs, an increase in the share of vegetables in the diet ordinarily will correct the fault.

Iron is equally vital and may be supplied by that old stand-by, spinach. The dinner-table motto, "Eat your spinach and get your iron," is not so far wrong as some people believe. Other green vegetables, too, are good sources, and while probably less than half of the iron in most vegetables is available for the body, still they furnish substantial amounts.

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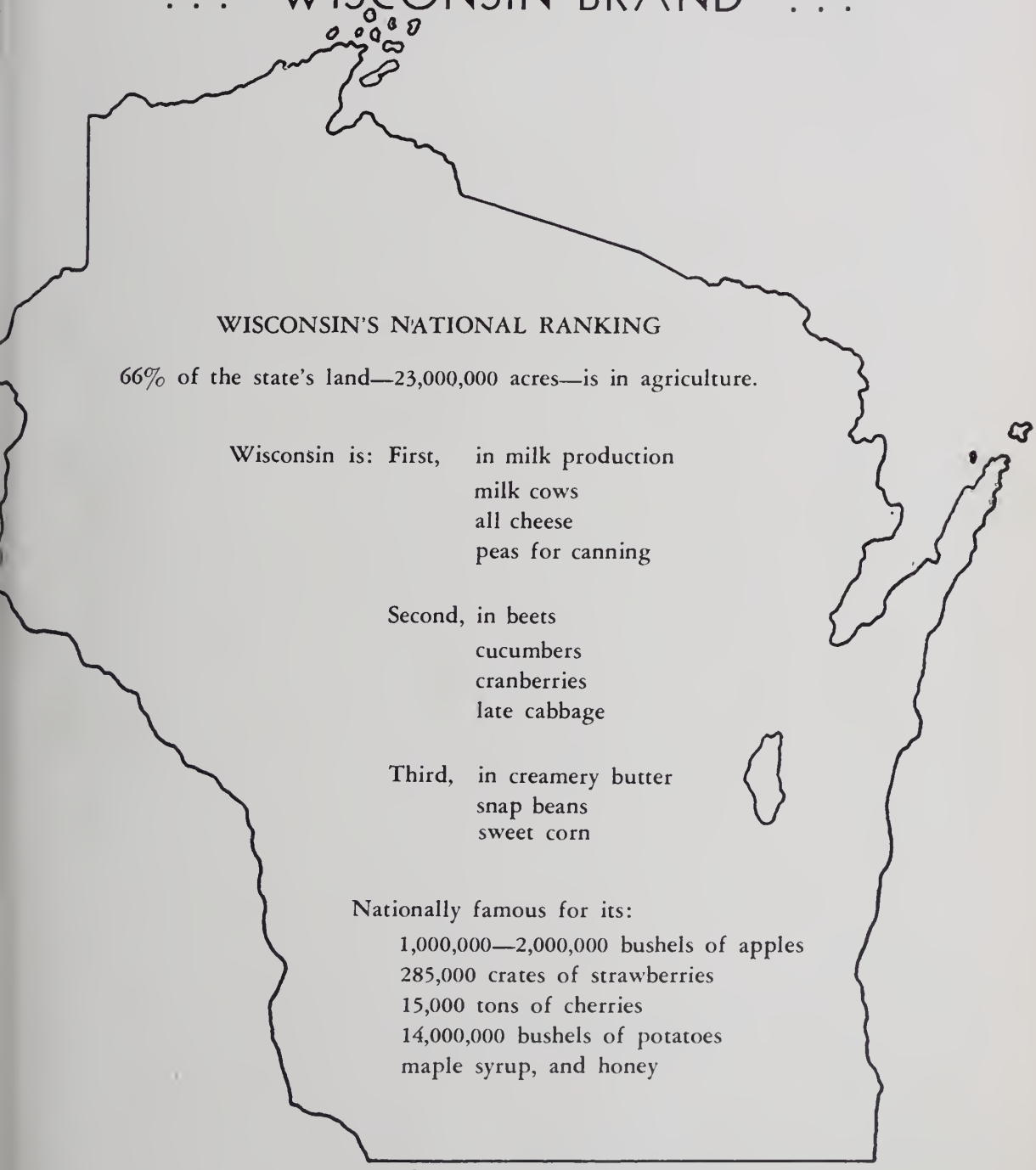
. . . "WISCONSIN BRAND" . . .



WISCONSIN'S NATIONAL RANKING

66% of the state's land—23,000,000 acres—is in agriculture.

Wisconsin is: First, in milk production
milk cows
all cheese
peas for canning

Second, in beets
cucumbers
cranberries
late cabbage

Third, in creamery butter
snap beans
sweet corn

Nationally famous for its:
1,000,000—2,000,000 bushels of apples
285,000 crates of strawberries
15,000 tons of cherries
14,000,000 bushels of potatoes
maple syrup, and honey

. . . One of the Three Healthiest States in the Union . . .

Another important mineral, copper, is found in small but significant amounts in most garden vegetables.

Vegetables are much weaker in the field of supplying energy to the body than are sugars, fats, oils, and meats, which adequately meet this need. But, the importance of vegetables to health is not measured by the energy they give (the exception to this rule is potatoes, which are important for fuel).

The Body Needs Regulators

The construction and maintenance of the body testifies that it is a well-planned machine, and as a machine we must recognize that it has certain functioning needs. It must, of course, have fuel to burn and to convert into energy. But it must also have lubricants and regulators. It must have proper timing and treatment to work at top efficiency.

Vegetables, supplying vitamins and minerals, solve these problems of regulation. Just as vitamins and minerals stabilize and encourage normal growth, and just as they help produce a healthy body, so they help to regulate the functioning of that body.

Minerals, for instance, help control digestion. They constitute a safety valve, too, which keeps an alkaline reserve in the blood stream to help neutralize excess acidity. Vegetables are important in supplying the minerals vital to the digestive process and in furnishing bulk and roughage, also important in digestion.

Many things enter into the question of healthy nerves. But an adequate mineral supply is one factor which helps regulate the functioning of the sensitive nervous system.

Vitamins have a regulatory function, too, and appetite, digestion, and the proper functioning of the nervous system are all partially dependent on adequate vitamins. Again vegetables are an important source of supply.

Those Vital Vitamins

Let's step over to that vitamin classification to see just what vegetables have to offer.

All green leaves and green vegetables such as spinach, lettuce, and chard, and most yellow foods such as carrots, squash, and sweet potatoes, contain carotene, which can be converted to vitamin A in the liver. Vegetables supplement the dairy foods, therefore, in supplying the first vitamin, A.

Next on the list is thiamin, also spoken of as vitamin B_1. Thiamin is the vitamin of morale, one of the B-complex vitamins which is important to nervous stability. Its chief sources are lean meats, particularly pork, along with whole grain products, whole wheat flour and whole wheat cereals. But fresh peas and lima beans are excellent sources, and cabbage, carrots, spinach, and lettuce are good sources of thiamin.

Riboflavin, another B-complex vitamin which affects nervous balance and the digestive process, is found to some extent in peas and beans, in leafy vegetables, and in lesser amounts in corn. Vegetables are not the best source of this vitamin, which can be obtained more efficiently from milk, lean meat and liver, but they are helpful in insuring the riboflavin supply.

Nicotinic acid is less plentiful in vegetables than in meats and meat products. Peas and beans are fair sources of that antipellegra factor, but other vegetables carry very small amounts.

Vitamin C is also important to nutrition, and here another vegetable comes into the picture. Tomatoes are one of the best economical sources of vitamin C, and their appearance in the diet is a guarantee of vigor and of resistance to infection. Cabbage is very high in vitamin C content, and spinach, lettuce, turnips and peas are good sources.

In supplying the sunshine vitamin, D, fish oils are important, and exposure to sunlight is also a factor. Vegetables are of small consequence in that regard, although the leafy vegetables contain a very little vitamin D.

Protective Foods Are Needed

If any major mineral or vitamin elements are missing, then the body falls into disrepair, for it cannot function smoothly and efficiently without these body lubricants and regulators. That is why E. V. McCollum, who isolated vitamin A when he worked at the University of Wisconsin almost thirty years ago, later designated the foods which

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WHAT VEGETABLES DO FOR US

The Body Needs:			It Gets Them From:
ENERGY	Carbohydrates	Starches	*Potatoes and other starchy vegetables* Cereals
		Sugars	Sugar and syrup Honey and molasses
	Fats		Butter and cream Meat fats Cheese Other fatty foods
BUILDING AND REPAIR MATERIALS	Proteins		*Beans and peas* Meats Dairy products and eggs Cereals
	Minerals	Calcium	*Green vegetables* Dairy products
		Phosphorus	*Beans and peas* Meats Cereals (whole grain) Dairy products and eggs
		Iron	*Green vegetables* Meats and eggs Cereals (whole grain) Dried fruits
REGULATORY AND PROTECTIVE FOODS	Vitamins	A	*Green and yellow vegetables* Dairy products Fish liver oils
		Thiamin	Cereals (whole grain) Meat *Green vegetables*
		Riboflavin	Meats *Green vegetables* Milk and eggs
		Nicotinic Acid	Meats Whole grain cereals *Beans and peas*
		C	*Tomatoes and cabbage and other raw vegetables* Fruits
		D	Fish liver oils Dairy foods Eggs

supply mineral and vitamins as "protective" foods, essential to the health of the body.

McCollum's earliest protective foods were milk and green vegetables. Now the concept has been expanded to include fruit and eggs as well, and modern biochemistry recognizes that all these foods are protective and efficiency-promoting. But, vegetables are still near the top of the list.

Vegetables Are Not Fuel Foods

All classes of foods have certain characteristics. Sugars and fats, for instance, supply heat and energy. Meats are generally rich in proteins and in some of the B-complex vitamins. Breadstuffs, if milled from whole grain, supply thiamin and are also rich in protein and energy. But, vegetables have their role in nutrition elsewhere, a role as important as that of any other class of foods.

Vegetables do not have their greatest worth as a food for fuel. Their important function is that of a food for protection and for the greatest degree of health.

One other factor has not been considered in this study of the nutritional value of vegetables. Vegetables are low in calories, high in roughage. In other words, they can supplement a concentrated diet high in protein and calories, supplying vitamins and some of the bulk which is important to digestion.

They can also be used to advantage in a diet designed to reduce the caloric intake. For the reducing diet, lettuce, cabbage, and spinach are very valuable, because they give a good supply of certain much-needed nutrients; they offer bulk and yet they are low in calories and are non-fattening. While the leafy vegetables are outstanding in this respect, most vegetables have some value.

The Food Plan is a Year-Round Job

Another important point to consider in measuring the nutrient value of vegetables in the diet, is that they are available all year round at reasonably low cost. Root crops keep well in cellar storage, and other vegetables can be prepared by drying, canning, or bottling.

That brings us to a question which housewives frequently ask. What effect does canning have on food value?

THERE'S A USE FOR EVERY VEGETABLE AND A VEGETABLE FOR EVERY USE

Potatoes and other starchy vegetables, are a source of carbohydrates for energy.

Green, leafy vegetables—lettuce, spinach, and others—yield iron, calcium, copper and other much-needed minerals.

Yellow vegetables, such as sweet potatoes, and carrots, offer carotene, from which the body can produce vitamin A.

Tomatoes and cabbage are rich in vitamin C.

The legume vegetables, beans and peas, yield such B-complex vitamins as thiamin, riboflavin, and nicotinic acid.

All vegetables are good sources of most vitamins, and they are all substantially rich in minerals.

Is Canning Harmful?

Canning is a process of preserving foods by heating them to a sterilization point and then sealing them in air-tight containers. It is a fairly simple process, and yet, in times past, its very simplicity brought it under suspicion. "If foods can be preserved that easily," people once said, "canning must harm them some way."

That doubt seemed to be confirmed by the occasional spoilage of cans or bottles of foods, and not until 1895, when H. L. Russell of the Wisconsin Agricultural Experiment Station first applied bacteriology to canning, did most people admit that canned foods might be perfectly wholesome.

Then, with the advent of the vitamin, suspicion arose again, and people began to wonder what effect heat had on the vitamin content of foods in the canning process. The first tests, made when the B-complex vitamins were still classed as a single vitamin B, indicated that canned vegetables lost much of that vitamin during the cooking process. The tests indicated that vitamin C, too, was largely lost, and cast a shade of doubt around the nutritive value of canned foods. But

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THE NATION AT WAR

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Physicians and Tire Rationing

By MR. DON T. ALLEN
State Rationing Administrator, Milwaukee

UNDER the eligibility classification issued by the Office of Production Management are listed certain vehicles which may be equipped with new rubber tires or tubes. Included among these are vehicles which are operated by a physician, surgeon, visiting nurse, or a veterinary, when such vehicles are used principally for professional services; ambulances; and vehicles used to enforce such laws as relate specifically to the protection of public health and safety. Physicians and surgeons, as interpreted under Section 404 (a), Tire Rationing Regulations, issued December 30, 1941, include persons licensed as physicians or surgeons to practice in a particular state.

To obtain tires or tubes under the present regulations,

1. The physician must inform one of his local inspectors of his needs. Inspectors are appointed by local rationing boards and include most tire dealers. The inspector examines the tires on the physician's car, fills out an application blank which the physician must sign, and files the application with his statement of the condition of the physician's tires, with the local rationing board. If there is any question concerning the need for tires, the local rationing board delegates another inspector to make an examination.
2. When the rationing board has approved the application, which under the present regulations will probably be at once unless there is some question of the need, it issues a purchase order which must be signed by the purchaser in the presence of the secretary of the board.
3. The physician may then take the purchase order back to the original inspector to be filled or he may take it to any other dealer whom he chooses.

About 98 percent of our normal supply of crude rubber comes from the Far East. Interruptions in communications and adoption of the destructive "scorched earth" policy resulting from the Japanese attack probably mean elimination of the Far East as a source of supply for a long time to come. We must rely therefore on our stock pile of this vital material which has been accumulated for just such an emergency.

The stock pile contains the largest amount of rubber ever held in the United States, but it would be exhausted in a few months if normal civilian consumption were allowed to continue.

To conserve our rubber supply and to make possible the continuance of transportation services vital to the Army and Navy, industrial production, and civilian life, the Office of Production Management and its successor, the War Production Board, have issued a series of orders drastically curtailing the use of rubber. Rubber can no longer be used in quantity for civilian tires; the Office of Production Management therefore delegated to the Office of Price Administration the function of advertising the very limited supply of rubber tires which can be made available for civilian uses among those persons and enterprises which must be assured transportation if the community is to remain safe, healthy, and productive.

Since issue of the new tire and tube regulations on December 30, 1941, the rubber outlook has materially grown worse.

It is therefore necessary to extend the restrictions on purchases of tires. Until now, unrestricted purchases of retreaded and re-

capped tires and retreading and recapping services have been allowed.

On and after February 19, 1942, recapped and retreaded tires and recapping and retreading services may be purchased only by those persons who have been granted tire-rationing certificates by Rationing Boards.

The supply of crude rubber available for the manufacture of "camelback," the material used in retreading and recapping tires, is small. It is possible and even probable that there will be no crude rubber available for this purpose, except for vehicles already eligible for new tires and tubes.

Nevertheless, the full machinery for rationing retreaded and recapped tires and retreading and recapping services is now being set up for a broader list of eligible classes. The broad list of eligible classes has been set up to impart a high degree of flexibility to the rationing of whatever supply of camelback the War Production Board may allocate for retreading and recapping services.

The revised regulations give Rationing Boards discretionary power necessary to meet local needs and conditions within the limits imposed by the rubber shortage. This grant of discretionary power to Rationing Boards is a demonstration of the confidence which their performance to date has evoked in their ability to conserve our tire and tube supply for the essential needs of the Nation. In the light of the most recent information on the rubber outlook, the ability of the Rationing Boards to conserve our rubber supply becomes a matter of major importance.

There is in the rubber outlook no cause for optimism. If present expert estimates of synthetic production and imports of rubber from the Far East are actually exceeded by future performance, as now seems improbable, quotas for recapping and retreading tires of vehicles may be increased—unless military requirements increase in the same or greater proportion. Very substantial increases in military requirements are inevitable.

Transportation problems which will result from the rubber shortage are now under study by the Government. It is recognized that some provision must be made for transportation of those persons whose activities are essential to the war program, public health, and public safety. The same recognition is given to the importance of transportation of essential materials and supplies.

The American economy has been based upon the automobile as an essential means of transportation. Consequently the problems arising from the rubber shortage are gigantic in their proportions. Full understanding and cooperation on every hand will be necessary to solve these problems.

Legal Relief For Physicians in Military Service

THIS article is limited to the protection afforded to certain of the civil rights of persons, including physicians, in military service of the United States under the provisions of the federal Soldiers' and Sailors' Civil Relief Act of 1940.

Instead of digesting the Act, it has been thought more useful to summarize, under convenient topical heads for the busy professional reader, those provisions of the Act which relate to points of general or specific interest to the physician. For earlier treatment of the subject, the reader is referred to the Blue Book issue of *The Wisconsin Medical Journal,* December, 1941, page 1170, and to *The Journal of the American Medical Association,* January 24, 1942, page 306.

The express purpose of the Act is to protect from impairment certain civil rights of those in military service during the period of such service. The Act endeavors to accomplish this end by suspending enforcement of certain civil liabilities, and by temporary suspension of legal proceedings and transactions which may prejudice the civil rights of persons while in service.

Coverage of the Law

Persons covered.—Those covered by the Act include the United States Army, Navy,

Marine Corps, Coast Guard, all officers of the Public Health Service detailed for duty either with the Army or the Navy. The period of coverage includes federal service on active duty with any branch above referred to, as well as training or education under the supervision of the United States preliminary to induction, including, in the case of all persons in military service, absence on account of sickness, wounds, leave or other lawful cause.

General legal relief.—Various types of relief are extended defendant physicians during military service and for specified times thereafter. This includes relief against judgments taken by default, relief against the enforcement of fines or penalties, stay of execution, the vacating or stay of attachment or garnishment, and the exclusion of periods of military service in computing any statute of limitations for the bringing of an action by or against a person in military service.

Eviction from homes.—During the period of military service, no eviction of a wife, children or other dependents of a person in military service is permitted as to premises occupied chiefly for dwelling purposes by such dependents for which the agreed rent does not exceed $80 per month, except by court authority. To obtain this relief, a showing must be made that ability of the tenant to pay the agreed rent has been materially affected by reason of such military service.

Instalment contracts.—No owner of real estate, or of personal property such as cars or professional equipment, who has received, under a contract of purchase or lease with the intent of purchase of such property, any deposit or instalment of the purchase price *prior* to the effective date of the Act, which was October 17, 1940, may exercise any right or option under such contract to rescind or terminate the contract, or resume possession of the property for non-payment of any instalment falling due during such military service, except by court action.

Repossession of a motor vehicle, tractor or accessories, or an order for sale, where such property is encumbered by a purchase money mortgage, conditional sales contract, or lease, will not be stayed by a court unless 50 per cent or more of the purchase price has been paid by the purchaser who is in service.

Mortgages.—Similar relief and stays are afforded persons in service as to mortgages on real estate or personal property given prior to October 17, 1940, where such mortgaged property is owned by the person when military service began, and is still owned by him when enforcement of payment is attempted.

Life insurance.—A person in military service may have the payment of premiums on $5,000 in face value of life insurance guaranteed by the Administrator of Veterans' Affairs, in order to prevent lapse or forfeiture. Persons so protected, within one year after leaving military service, may pay up back premiums and resume payment of regular premiums, and upon failure to do so the policy lapses and the cash surrender value accrues to the government to the extent necessary to meet the cost of premiums which it guaranteed. These provisions are applicable only to insurance contracts in force prior to October 17, 1940, on which a premium had been paid either prior thereto, or not less than thirty days before military service of the insured individual began.

This protection is not available where the premiums are unpaid more than one year at the time application for benefit is made by the insured person in service, nor to any policy on which there is outstanding a policy loan or other indebtedness equal to or greater than 50 per cent of the cash surrender value, or to policies which are void or otherwise subject to modification in case of military service.

Property taxes.—Property of a person in military service is exempt from sale to enforce the collection of a tax or assessment except by leave of the court, which also may grant a stay of proceedings or sale up to six months after termination of military service where the owner in military service files with the proper tax authorities an affidavit describing the property, showing that a tax or assessment has been made, that it is unpaid, and that by reason of military service

the owner's ability to pay the tax or assessment has been materially affected.

The above benefits are limited to real estate owned and occupied for dwelling, agricultural or business purposes, by a person in military service, or his dependents, when service began, and which continue to be so occupied by such person's dependents or employes at the time such subsequently accruing taxes fall due.

Income taxes.—A person in military service is entitled to a deferment not exceeding six months after termination of his period in service, for payment of state or federal income taxes, whether falling due prior to or during his period of service, providing his ability to pay has been materially impaired by reason of such service. No interest or penalties accrue during such period of deferment by reason of non-payment.

Sureties.—Where relief is granted to a person in military service, such stay, postponement or suspension of proceedings may, in the discretion of the court, likewise be granted to sureties, guarantors, endorsers and others subject to the obligation or liability. Thus physicians who are not in military service may be the beneficiaries of the Act where they have signed obligations as sureties, guarantors or endorsers for one who is in service.

Limitations and Non-Coverage

Civil Process.—A person in military service is not free from service of civil process. Such process may be served while he is on military property. The Act only suspends temporarily certain legal proceedings and transactions or the enforcement of certain civil liabilities, and is not intended to prevent the bringing of such legal proceedings.

House leases.—The best present opinion, in the absence of court decisions, is that protection is not afforded in any of the four following situations: (1) where the agreed rent exceeds $80 per month; (2) where the dependents wish to quit the premises before the lease expires because rent is too high or for any other reason legally insufficient to terminate a lease; (3) where the lease terminates while the head of the house is in military service and the family desires to stay but the owners are unwilling; (4) where the house is sold and a lease provides for its own termination after passage of a certain time following sale.

Office leases.—Leases on property occupied for office purposes by a physician or others in military service are not protected by the Soldiers' and Sailors' Relief Act. Separate legislation for this purpose is pending but has yet to be acted upon.

Instalment purchases.—The Act affords no protection to a person in military service as to real estate or personal property under either of the following two circumstances: (1) where the contract was made or the first deposit or instalment tendered *subsequent* to October 17, 1940, the date on which the Act took effect; or (2) where the instalment contract is violated in any respect other than by non-payment of an instalment. Thus, if a car being purchased on instalments were removed to another county without consent of the owner, or a house which was being purchased under land contract was not maintained in accordance with the terms of the contract, such violation might warrant repossession by the owner even though the purchaser were in military service.

Summary

It should be emphasized that the Soldiers' and Sailors' Act, far from being inclusive, is very limited in its scope and in the remedies it affords; that there is nothing automatic about its functioning; that the physician in service or his family have the burden at all times of being diligent to see that their rights under the Act are asserted in a timely and proper way; and that while the Act applies to certain types of contracts and transactions of persons in military service, it offers no such protection for similar obligations of members of the family or other dependents of such persons. Finally, it should be emphasized that the physician must not rely either on chance or on the omniscience of the courts to guide his affairs through the complications which inevitably attend military service. He should consult an attorney promptly and formulate a plan which will afford him and his family maximum protection in his absence.

Emergency Medical Defense Needs Outlined

R. E. FITZGERALD, M. D.

DR. R. E. FITZGERALD, chairman of the Committee on Medical Defense of the State Medical Society and chief of the Emergency Medical Service of the Wisconsin Council of Defense, addressed the mid-winter session of the Board of Directors of the Woman's Auxiliary to the State Medical Society in Milwaukee on February 4. His subject was emergency care of the civilian population in war.

Outlining the activities of the State Medical Society and the responsibility of the county chiefs of Emergency Medical Service, Dr. Fitzgerald declared, "The local chief of Emergency Medical Service is responsible for the preparation and promotion of medical plans for civilian protection from the hazards of enemy action. The organization of an effective Emergency Medical Service can be developed only through an active local chief, who can achieve a uniform and comprehensive organization with his county. We are urged by the chief medical officer of the national defense organization promptly to organize Emergency Medical Service throughout the state so that it may be integrated into the nationwide pattern of civilian defense."

Pointing out that the local chief of Emergency Medical Service is charged with an important responsibility in the preservation of public morale, Dr. Fitzgerald urged prompt cooperation by the medical profession in Wisconsin in the development of the medical defense program. He urged local chiefs of Emergency Medical Service to consult with the State Medical Society of Wisconsin in developing their programs and stated, "The continued availability of Wisconsin resources in the national picture must be protected whenever and wherever possible through the facilities of the medical profession."

PROCUREMENT AND ASSIGNMENT SERVICE

Various issues of *The Journal of the American Medical Association,* and this section of *The Wisconsin Medical Journal,* have provided physicians with information and announcements pertaining to the Procurement and Assignment Service for physicians, dentists and veterinarians.

The particular attention of members is directed to the February 21 issue of *The Journal of the American Medical Association* which, on pages 625 to 638 inclusive, compiles detailed information concerning the organization, activities and effect of the Procurement and Assignment Service. Personnel of the corps area committees, pertinent regulations, and other valuable information are given in this detailed article.

Of particular importance to physicians in all states is the information available with reference to individual classifications of physicians, including specialists, interns, hospital staff members and others. The plans for Procurement and Assignment Service to send questionnaires directly to all physicians, dentists and veterinarians, and the effect of individual physicians offering their services through the questionnaires, are treated in detail. Members of the State Medical Society of Wisconsin are urged to familiarize themselves with this material.

. . . . THE PRESIDENT'S PAGE . . . .

Stay on an Even Keel

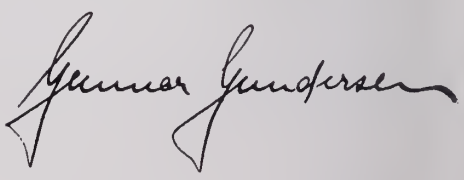
STAYING on an even keel is difficult at best and all the more so during periods of unrest. In times of emergency and war this becomes particularly true so that restiveness becomes a dominant symptom in Homo sapiens. At the present time, we of World War 1 memory are reliving and recapturing the many and varied inconsistencies of that period. In times such as these it is only natural for humans to oscillate to extremes and to such a degree that oftentimes we do ill-considered things and behave in a manner, on the spur of the moment, of which later, in the light of more sober judgment, we have no reason to feel very proud.

Now that we are at war your State Medical Society is in a position to accomplish for its membership additional acts of real service. Its office serves as an emergency clearing house for all the orders, regulations, and innumerable other matters which flow continuously, not only from headquarters of the American Medical Association but from the Procurement and Assignment Service, the Selective Service Headquarters, and other governmental agencies. The constant flood of requests to headquarters for information, guidance, and advice is merely one indication of the real value of a strong central organization at this critical time.

That the office of the State Medical Society may function untrammeled is of paramount importance to the staff. Thereby, more time will be granted to it in its aid to our country in our prosecution of the war effort. As far as it is possible the officers should be spared time-consuming and unnecessary detail. Service to its membership, however, is still the keynote of the staff. On the other hand, the individual member has a real responsibility to the central office, and that is maintenance of his membership in good standing.

Dues for the calendar year 1942 have been payable since January 1. By and large, it is encouraging to note that members have remitted perhaps more promptly this year than in some of the years immediately past. County secretaries are trust officers of their members and for the most part have acted cooperatively in making periodic remittances to the Society so that the physical resources of that office may not be overwhelmed in the last minute rush to remit before the dead line of April 1. The State Medical Society of Wisconsin is properly chary with the accolades it may award, but they are abundantly granted to those county secretaries who so generously serve in assisting their profession and its Society. If it were not for their understanding, complete cooperation and the faithful discharge of their duties, the profession of medicine would fail in its responsibility to the public.

Our objective of welding the profession into an articulate group through the component county medical societies has never been clearer or more desirable than at present. Every member of the Society is responsible to the accomplishment of that objective; county society officers must function to that end, not in "lip-service" to their office, but in a manner to justify the confidence placed upon them by the membership they represent.



THE WISCONSIN MEDICAL JOURNAL

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Annual Subscription ---------- Three Dollars-Fifty Cents Single Copies ---------- Fifty Cents

Advertising Representative: Cooperative Medical Advertising Bureau, 535 North Dearborn St., Chicago, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, Madison

Volume 41 MARCH, 1942 Number 3

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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« « « EDITORIAL » » »

56,000

FIFTY-SIX thousand times during the year the opportunity is presented Wisconsin physicians to urge upon mothers of the newborn those protective procedures that are in the interest of their child's better health. The physician's guiding hand in the early months of life is welcomed by the mother because of the instinctive desire that lies deep in the maternal heart for health and protection of her baby.

Fifty-six thousand times during the year the opportunity is presented Wisconsin physicians to emphasize that the child should be immunized against diphtheria, vaccinated against smallpox, and protected against whooping cough. Each of these mothers depends upon the physician to advise and counsel her on health procedures for her baby.

The profession in Wisconsin can point with pride to the enviable record that has been achieved in the low incidence of these diseases in Wisconsin and in the low mortality from such causes. If we are to maintain this record, however, each physician must conscientiously devote himself to a continuance of the administration of preventive procedures that are known to him to be effective and in the interests of the health of the child and the community.

It is the responsibility of the profession to urge upon the mothers of the 56,000 new Wisconsin babies each year the importance of immunization against diphtheria, vaccination against smallpox, and protection against whooping cough.

CHILD HEALTH DAY--1942

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

A PROCLAMATION

WHEREAS the Congress by joint resolution of May 18, 1928 (45 Stat. 617), has authorized and requested the President of the United States to issue annually a proclamation setting apart May 1 as Child Health Day:

NOW. THEREFORE, I, FRANKLIN D. ROOSEVELT, President of the United States of America, in recognition of the vital importance of the health of children to the strength of the Nation, do hereby designate the first day of May of this year as Child Health Day.

And I call upon the people in each of our communities to contribute to the conservation of child health and the reduction of illness among children by exerting every effort to the end that before May Day, Child Health Day, children over nine months of age be immunized against diphtheria and smallpox, the two diseases for which we have the surest means of prevention.

IN WITNESS WHEREOF I have hereunto set my hand and caused the seal of the United States of America to be affixed.

DONE at the City of Washington this 6th day of February in the year of our Lord nineteen hundred and forty-two and of the Independence of the United States of America the one hundred and sixty-sixth.

Franklin D. Roosevelt

By the President:

Cordell Hull

Secretary of State.

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. J. S. Supernaw, Madison, President
Mrs. E. S. Schmidt, Green Bay, President-Elect
Mrs. J. Gurney Taylor, Milwaukee, Vice-President
Mrs. E. H. Townsend, La Crosse, Recording Secretary
Mrs. H. L. Greene, Madison, Corresponding Secretary
Mrs. E. P. Bickler, Milwaukee, Treasurer
Mrs. W. E. Sullivan, Madison, Parliamentarian

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Convention—
Mrs. E. J. Carey, Wauwatosa
Finance—
Mrs. R. E. Fitzgerald, Wauwatosa
Hygeia—
Mrs. A. C. Taylor, Appleton
Organization—
Mrs. O. W. Friske, Beloit
Philanthropic—
Mrs. J. W. MacGregor, Portage
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Mrs. F. W. Aplin, Waukesha
Program—
Mrs. C. N. Neupert, Madison
Public Relations—
Mrs. D. H. Jeffers, Lake Geneva
National Exhibit (special committee)—
Mrs. W. Homer Krehl, Madison
Circulation of Bulletin (special committee)—
Mrs. Charles Fidler, Milwaukee
Legislation (special committee)—
Mrs. H. Kent Tenney, Madison

Report of Midyear Meeting of Board of Directors

By MRS. E. H. TOWNSEND
La Crosse

THE midyear meeting of the Board of Directors of the Woman's Auxiliary to the State Medical Society of Wisconsin was held on February 4, in the club rooms of the Hotel Schroeder, Milwaukee. Following the luncheon, Dr. R. E. Fitzgerald, chairman of the State Society's Committee on Medical Defense and state chairman of Assignment and Procurement Service, discussed what Auxiliary members can do in the war effort. Thirty-eight members were present, Mrs. J. S. Supernaw, president, presiding.

Mrs. Supernaw thanked the chairmen for their cooperation and interest, and urged that county secretaries report the names of new officers. She reported having attended the National Board meeting in Chicago and having visited four county auxiliaries.

REPORTS OF OFFICERS AND CHAIRMEN

In the absence of the treasurer, Mrs. E. P. Bickler, Mrs. R. E. Fitzgerald reported on finances. Mrs. H. L. Greene read a report of the midyear meeting of the national Board of Directors, as presented by Mrs. R. E. Ahlquist, national corresponding secretary.

Mrs. Eben J. Carey, convention chairman, announced that plans are being formulated for the state convention to be held from September 14 to 16. The Walworth Auxiliary volunteered its assistance as a co-hostess.

The nominating chairman, Mrs. J. W. MacGregor, was unable to make a report concerning delegates to the national convention, but set April 15 as a tentative date for a meeting of her committee.

Press and Publicity

Mrs. F. W. Aplin, chairman of press and publicity, reported having sent twenty-seven letters to county auxiliaries, outlining the duties of county, press and publicity chairmen. Twenty-five auxiliaries responded and twenty-two have reported on their meetings. Eleven counties described outstanding study programs, including such subjects as public health, defense and legislation. Twelve auxiliaries reported philanthropic work, which included work on such projects as Red Cross, loan closets, gifts to hospitals and institutions, layettes, flowers to shut-ins, community projects and Girl Scout troops. Five counties indicated lively cooperation in programs on medical defense, and eight counties an interest in *Hygeia.* Eight counties used convention reports in their programs; two used articles from the *Bulletin,* one from *The Wisconsin Medical Journal* and one from *Hygeia.* Mrs. Aplin further reported that four monthly news reports have been sent to the national press and publicity chairmen, that correspondence has included the writing of 116 letters and that space for

Auxiliary news has been given by *The Wisconsin Medical Journal.*

Program

Mrs. C. N. Neupert, program chairman, suggested the following topics for programs: nutrition, socialized medicine, parliamentary law, public health, Women's Field Army, legislative problems, and defense work.

Three counties have program booklets, and Mrs. Neupert thinks every county would benefit by planning its year's schedule in advance, to consist of one meeting devoted to annual business, two to health talks, one to public relations, one to social entertainment, and one to legislative matters, leaving others to be filled as desired, with possibly a talk by the chief of Emergency Medical Service.

Hygeia

Mrs. A. C. Taylor, *Hygeia* chairman, reported 942 Auxiliary memberships and 445 *Hygeia* subscriptions. The quota of one subscription per member is not being met, although at the present time the information in *Hygeia* is more than ever needed. County *Hygeia* chairmen were urged to stress the educational advantages of *Hygeia* and to arrange to promote its availability to persons who cannot subscribe.

Philanthropy; Public Relations; Archives

Mrs. J. W. MacGregor, philanthropic chairman, and Mrs. D. H. Jeffers, public relations chairman, reported satisfactory progress in this work. Mrs. Jeffers thinks that more meetings should be open to those who appreciate what our organization has to offer in speakers, and the health knowledge that we, as Auxiliary members, can share. Mrs. J. P. Connell, archives chairman, urged the county auxiliaries to continue keeping scrapbooks of their activities and to submit to her the histories of pioneer physicians.

REPORTS OF COUNTY PRESIDENTS

The reports of the county presidents proved interesting, showing advancement and a fine spirit of cooperation.

Mrs. J. K. Shumate, president, Ashland–Bayfield–Iron Auxiliary, was unable to be present, but sent a report stating that members are active in the Red Cross, in summer health round-up work, and on a committee sponsoring hot lunches in the schools.

Mrs. G. N. Lemmer, president, Barron–Washburn–Sawyer–Burnett Auxiliary, sent a report that they have started compiling personal histories of the pioneer doctors, are working on a scrapbook, and are taking an active part in Red Cross and defense work. She wrote with enthusiasm of their meetings and accomplishments, in spite of the great distances between towns in these northern counties and the difficulties of travel.

Mrs. George Goggins, president, Brown–Kewaunee–Door Auxiliary, stated that they held a rummage sale and over-subscribed their quota for *Hygeia.* Members are doing outstanding work in Red Cross and helped with the registration for Selective Service. In their meetings they are trying to follow the theme of health and nutrition.

Mrs. W. A. Werrell, president, Dane Auxiliary, spoke favorably of the loan closet project which each year is becoming a more substantial contribution to Dane County. Their Auxiliary placed fifty nine-months subscriptions and twenty six-months subscriptions to *Hygeia* in Dane County rural schools and small libraries. The public relations chairman has placed speakers on the programs of Parent–Teacher Association meetings.

Mrs. W. C. Finn, president, sent a report from the Fond du Lac Auxiliary. This group is sponsoring a Girl Scout troop and has undertaken a new project, that of aiding the local Red Cross in their office and workroom, placing two members on duty every day.

The Kenosha Auxiliary report was given by Mrs. A. M. Rauch, president-elect. This group of thirty-four members is doing outstanding philanthropic work, such as a $5 donation to each hospital at Christmas time, $25 to the Red Cross, $5 to the infantile paralysis fund, and $7 for a community nativity scene. They sponsored a movie with a net profit of $104. A centennial tea was given for the public at which time representatives from every woman's organization in the city

were present to hear Dr. W. W. Bauer, director of the Bureau of Health Education of the American Medical Association. One hundred and fifty copies of "Health Achievements in Wisconsin" were distributed to guests at the tea, also to schools, hospitals and libraries.

Mrs. Gunnar Gundersen, president, La Cross Auxiliary, sent a report stating that membership has increased to forty-four. Members have been sewing each week for the Red Cross. A silver tea will be held in March, the proceeds of which will be used to buy *Hygeia* subscriptions for schools and industrial plants.

Mrs. C. E. Wall, secretary, reporting for the Manitowoc Auxiliary, stated that *Hygeia* reports and book reviews pertaining to health and medical history have been given at meetings. Biographies of county physicians are being compiled and donations have been made to poor relief.

Mrs. R. D. Champney, Milwaukee Auxiliary president, reported that members have responded to requests for help from the Civilian Defense Volunteer office. A motor corps has been organized. Other members have been assigned to interviewing civilian defense volunteers, teaching classes in home nursing, and doing clerical work. The study group reports having heard reviews of books which pertain to medicine and the lives of physicians.

Mrs. R. T. McCarty, president, Outagamie Auxiliary, reported active public relations and *Hygeia* committees.

Mrs. H. J. Hansen, president, Sheboygan Auxiliary, reported a speaker's bureau which has brought to lay groups health and medical knowledge.

Mrs. E. D. Sorenson, president, Walworth Auxiliary, reported interested and well-organized committees, and a goodly sum in the treasury out of which they anticipate purchasing an infant respirator for their county hospital.

Mrs. R. D. Jameson, president, Racine Auxiliary, stated that like so many other auxiliaries they are busy sewing and knitting for the Red Cross. At these meetings one member gives a five-minute review of an article from *Hygeia.* They have given thirty-five subscriptions, money being raised by benefit card parties, and they have eighty-three paid subscriptions in the Auxiliary. This county also sponsors a Girl Scout troop.

The Washington–Ozaukee Auxiliary, according to its president, Mrs. M. E. Monroe, celebrated at a luncheon in West Bend in honor of its fifth anniversary. A birthday cake was presented to the first president, Mrs. H. M. Lynch, and a resume of the first five years was given by Mrs. A. H. Heidner. Mrs. R. S. Fisher was presented with a gift in recognition of her faithful attendance at meetings, having missed but once in five years. Members contributed to a needy family at Christmas time.

Mrs. W. N. Linn, president, Winnebago Auxiliary, wrote that at their November meeting Christmas table decorations were made and given to the Winnebago State Hospital. Their meetings include speakers on mental hygiene, child guidance, and what doctors wives should know about first aid. They are also working for the Red Cross and civilian defense.

ADJOURNMENT

In closing the meeting, Mrs. Supernaw urged closer study of legislation and the use of the *Bulletin* in planning programs. It was suggested, also, that more credit be given our state *Bulletin* chairman, Mrs. Charles Fidler, by sending subscriptions from counties direct to her instead of to the national chairman.

TO COUNTY AUXILIARY PRESIDENTS:

Is your chairman of press and publicity sending news of your County Auxiliary activities to the state chairman of press and publicity?

We want to know about your programs, your projects, and your social events.

Archives

By MRS. JAMES P. CONNELL
Fond du Lac

IN THE current *Bulletin of the Woman's Auxiliary to the American Medical Association*, our national chairman of archives, Mrs. Charles E. Sears, says, "Archives are completed records."

The State Medical Society is starting its second century of organization and achievement in Wisconsin. There is much that the Auxiliary can do to complete the history of the first one hundred years and launch into a comprehensive record of the years ahead.

1. There are still many histories of our pioneer doctors lacking. Let each Auxiliary check the early history of its community as well as the records of the Medical Society, list the men who were active in pioneer days, and prepare their histories to be filed with the State Historical Society. With this work accomplished, one of the vital reasons for the existence of our Auxiliary will be fulfilled.

2. Every Auxiliary should keep a filing system or scrapbook of letters and newspaper clippings concerning its program. Also personal items which concern deaths, births, marriages, and the accomplishments of its members should be filed.

This most important year of 1942 will find many of our doctors entering military and naval service. Keep a record of all these men.

The program of any organization can be fully developed only through the proper functioning of the various groups and the wholehearted cooperation of individuals. It is necessary for every Auxiliary in the State to do its part in getting all the facts possible for its records. These files and scrapbooks will be a public record of worth-while activities of the State Medical Society and its Auxiliary, and will be of historical interest in the future.

Finance Committee

By MRS. R. E. FITZGERALD
Wauwatosa

IT IS difficult to endow the financial aspect of an organization with interest, yet a knowledge of the sources of income and the expenditure of funds should be shared by all Auxiliary members. In planning our expenditures we do so on the basis of income derived from dues plus the annual contribution of $100 from the State Medical Society of Wisconsin. The estimated income from these two sources for 1941–1942 is $700.

Following is the budget as approved by the voting body at the state meeting in Madison in September, 1941:

Income from dues	$600.00
Income from State Society	100.00
Total amount available	$700.00
Budget	
President	$100.00
Corresponding Secretary	3.00
Treasurer	25.00
Archives	5.00
Hygeia	12.50
Miscellaneous	144.00
National Dues	300.00
Organization	40.00
Philanthropic	2.00
Press and Publicity	7.50
Program	3.00
Public Relations	3.00
Nominating Committee	5.00
Total	$650.00
Surplus for reserve fund	50.00
Grand Total	$700.00

Note.—Lest any misunderstanding arise it may be well to point out that the expenses of the various departments are, in most cases, limited to postage. It is especially necessary to specify this in the case of the

Philanthropic Committee which, per se, does no philanthropy but collects reports of the philanthropic projects sponsored by the county auxiliaries.

Members will notice that the sum of $50 is set aside for a reserve fund. It is the hope of the Finance Committee that this practice will continue in order that a surplus may be built up which in time would make the Auxiliary independent, financially, of the State Medical Society, for it has always seemed to me that it is a contradiction for an organization which calls itself an auxiliary TO another, to ask aid FROM that parent group.

County Auxiliary Proceedings

Columbia—Marquette—Adams

The Woman's Auxiliary to the Columbia-Marquette-Adams County Medical Society met with the doctors on January 20 at St. Savior's Hospital at Portage.

Dr. J. W. MacGregor of Portage read material from national headquarters concerning medical civilian defense. This was followed by general discussion of the manner in which the communities could best carry out this important effort, to which Auxiliary members pledged their support. The Columbia County nurse and a nurse from Portage who were in attendance at the meeting outlined their organizational work.

At the short business meeting which followed, Mrs. R. B. Dryer of Poynette was elected secretary to fill the vacancy left by the death of Mrs. A. J. Frederick of Columbus.

Dane

Mrs. G. A. Cooper of Madison reports that the Woman's Auxiliary to the Dane County Medical Society had a bridge luncheon on February 9 at 1 p. m., at the home of Mrs. J. P. Dean, Madison. Twenty-seven members were present. Mrs. T. W. Tormey, Jr., chairman of the luncheon committee, was assisted by Mmes. S. A. McCormick, R. E. Campbell, E. F. Schneiders, and K. E. Lemmer.

Mrs. J. C. Doolittle reported on needs for the loan closet, which will be supplied.

A letter from Dr. C. O. Vingom, Madison, acknowledged the Auxiliary's offer to help in the national defense project. Three canteen courses, which members are urged to attend, are being given. Mrs. N. A. Hill, defense chairman, sent letters to all members informing them of these courses. A special unit of Auxiliary members for canteen work was suggested.

Mrs. W. A. Werrell, Madison, reported on the midwinter meeting of the Board of Directors of the Woman's Auxiliary to the State Medical Society. She described the splendid work being done by other Auxiliaries in the state.

Mrs. H. L. Greene, state corresponding secretary, who also attended this meeting, reported on a talk by Dr. R. E. Fitzgerald, Milwaukee. Dr. Fitzgerald is chairman of the State Medical Society's Committee on Medical Defense and also state chairman of the Procurement and Assignment Service.

Dodge

Mrs. A. A. Hoyer, Beaver Dam, reports that members of the Woman's Auxiliary to the Dodge County Medical Society held their January meeting at the home of Mrs. W. H. Costello, Beaver Dam. Mrs. R. R. Boyd, representing the Red Cross, presented working plans, in which she stressed the importance of the study of nutrition.

During the business session, Mrs. J. M. Welsch, president, announced the following committee chairmen for the ensuing year:

Hygeia—Mrs. A. W. Hammond, Beaver Dam
Press and Publicity—Mrs. A. A. Hoyer, Beaver Dam
Program—Mrs. R. R. Roberts, Beaver Dam
Social—Mrs. W. H. Costello, Beaver Dam
Sunshine—Mrs. E. C. Hoyer, Beaver Dam
Membership—Mrs. A. M. Rosenheimer, Beaver Dam
Parliamentarian—Mrs. E. H. Federman, Randolph
Public Relations—Mrs. R. E. Schoen, Beaver Dam
Archives—Mrs. E. P. Webb, Beaver Dam
Philanthropic—Mrs. R. F. Schoen, Beaver Dam

Refreshments were served at the close of the meeting by the hostess, Mrs. Costello.

Fond du Lac

Municipal Judge George M. St. Peter addressed members of the Woman's Auxiliary to the Fond du Lac County Medical Society on "Keeping the Normal Child Normal" at their meeting held January 22 at the home of Mrs. A. M. Hutter, Fond du Lac.

Mrs. W. C. Finn, president, presided at this meeting, which was attended by twenty-six members. Voting to aid the Red Cross in every way possible, the Auxiliary plans to have two members at the Red Cross headquarters each day.

The committee in charge of the meeting consisted of Mmes. L. A. Hoffmann, Campbellsport, and J. S. Huebner, O. M. Layton, C. W. Leonard, J. R. Longley, and P. G. McCabe.

Kenosha

Changing the title of his address from "Nutrition for Defense," to the more timely, "Nutrition for Victory," Dr. W. W. Bauer, radio lecturer and director of the Bureau of Health Education of the American Medical Association, gave an interesting, amusing and educational program for the Woman's Auxiliary to the Kenosha County Medical Society held at the Woman's Club, Kenosha, December 12. The occasion was a "centennial tea" in observance of the one hundredth anniversary of the State Medical Society of Wisconsin.

Mrs. E. F. Andre, Kenosha, reports that a large audience heard Dr. Bauer's talk and at the conclusion asked questions. He was introduced by Mrs. L. H. Lokvam, president. Mrs. C. E. Pechous was general chairman and was assisted by Mmes. L. M. Rauen, C. G. Richards, W. C. Kleinpell, and Theodore Sokow.

Opening the delightful afternoon was a short program of piano selections by Doris Kassel, whose numbers were "Nocturne" by Grieg, "Harmonica Player" by Guion, and "Romance" by Sibelius.

Presiding at the tea table following Dr. Bauer's talk were Mmes. H. E. Robinson, Frank Andre. H. M. Ripley, and C. R. Caughey. The table was attractively appointed with a centerpiece of white chrysanthemums and tapers, and the clubhouse was decorated with greens and candelabra.

The February meeting was held on the third at the home of Mrs. H. L. Schwartz, Kenosha. Assisting hostesses were Mrs. B. S. Hill and Mrs. Alexander Schlapik.

Dr. C. G. Richards, Kenosha, outlined the plans which have been made for Kenosha in case of a war emergency. Members voted to make a contribution to the infantile paralysis fund.

Mrs. A. M. Rauch, president-elect, conducted the business meeting in the absence of the president, Mrs. L. H. Lokvam. Dr. Helen A. Binnie presided at the tea table as refreshments were served. The table was attractively decorated with red candles and red carnations in a Valentine's Day theme.

La Crosse

The January meeting of the Woman's Auxiliary to the La Crosse County Medical Society, held at the home of Mrs. P. C. Gatterdam, La Crosse, was preceded by a one o'clock luncheon served in the recreation room by the social committee. Hostesses were Mmes. N. P. Anderson, E. H. Townsend, T. E. Shea and W. J. Jones. Mrs. F. H. Wolf reported that there were about thirty present, and that sewing occupied the group for the afternoon.

Milwaukee

On February 13 the Woman's Auxiliary to the Medical Society of Milwaukee County held its monthly meeting with a luncheon at Hotel Schroeder. The social committee had the tables beautifully decorated with primrose plants.

Mrs. R. D. Champney, president, greeted the members and guests, and then introduced Dr. C. W. Eberbach, president of the Medical Society of Milwaukee County. He commended the members on their ability to conform to the demands being made on physicians and their families during our present war.

Mrs. J. J. Adamkiewicz stated in her report to *The Journal* that the meeting was very short. The secretary read the minutes which were approved. Mrs. R. T. Gilchrist, *Hygeia* chairman, reported on the number of subscriptions. The Red Cross benefit took the place of the *Hygeia* benefit this year. Mrs. H. O. Zurheide, chairman of the Red Cross party, gave a preliminary report, and thanked her committee, especially the women who were successful in collecting 123 door prizes for the party. Mrs. W. C. Liefert reported on the progress of the civilian defense work and encouraged the enrollment of new volunteers.

Mrs. Champney then turned the meeting over to the program chairman, Mrs. R. E. McDonald, who introduced Lieutenant Commander Marion B. Sulzberger, Medical Corps, United States Navy, who spoke on "Cosmetics I Have Met." He said that most cosmetics are harmless but that in individual cases they have been fatal. The audience was amazed to know that the yearly expenditures for cosmetics in the United States is equal to the amount spent for automobiles.

Outagamie

Tentative plans for their annual open meeting and tea, to be held in the spring, were outlined at the meeting of the Woman's Auxiliary to the Outagamie County Medical Society held at the home of Mrs. R. T. McCarty, Appleton, January 22. Twenty-nine members were in attendance.

Mrs. McCarty, president, presided at the meeting. Committee reports were presented by the respective chairmen. A discussion on *Hygeia* was led by Mrs. A. C. Taylor, *Hygeia* chairman of the Woman's Auxiliary to the State Medical Society. This discussion resulted in a more thorough understanding of the purpose of *Hygeia* and enlisted the hearty support of the Auxiliary members.

The group also discussed a current project, the tabulation of the civic welfare and charitable activities of its members outside of their Auxiliary work.

Preceding the business meeting Mmes. McCarty, F. J. Huberty and G. T. Hegner were hostesses at a benefit buffet supper, the proceeds of which were to be used to supply *Hygeia* subscriptions to educational groups.

Polk

Mrs. C. A. Kelly, St. Croix Falls, was hostess to the Woman's Auxiliary to the Polk County Medical Society at their meeting on December 18. Eight members were in attendance.

The Auxiliary voted to buy a defense bond, and to give a donation to the Red Cross War Fund. Mrs. G. B. Noyes, Centuria, was appointed to work with Dr. L. O. Simenstad, chairman of the Polk County Medical Society's committee on medical defense.

A social hour, with Christmas caroling, followed the business meeting.

Racine

Mrs. F. W. Pope, Racine, reports that thirty-five members were in attendance at a meeting of the Woman's Auxiliary to the Racine County Medical Society at the home of Mrs. R. M. Kurten, Racine, on February 9. Mrs. Vilas Whaley gave a resume of current events.

Mmes. R. J. Schacht and W. F. Konnak poured at the tea which followed the meeting. Other assisting hostesses were Mmes. Pope, R. W. Kreul, L. E. Fazen, C. E. Constantine and F. B. Marek.

Rock

The Woman's Auxiliary to the Rock County Medical Society met at the Hotel Hilton, Beloit, for a dinner meeting Tuesday, January 27.

Following a short business meeting conducted by the president, Mrs. C. R. Gilbertsen, Janesville, members joined the Rock County Medical Society to hear an illustrated lecture by Dr. Peter C. Kronfeld, medical director of the Illinois Eye and Ear Infirmary. His subject was "Five Years at the Pekin Union Medical College." This college was established by the Rockefeller Foundation to train Chinese young men in medicine. He also discussed diseases prevalent among the Chinese.

Sheboygan

Mrs. W. G. Huibregtse was hostess to the Woman's Auxiliary to the Sheboygan County Medical Society at a two o'clock dessert at her home on February 4, reports Mrs. W. W. Van Zanten, Sheboygan.

In a resume on current literature presented by Miss Marie W. Barkman, chief librarian at the Mead Public Library, two books were reviewed at length: "Mission to Moscow" by Davies, and "The Doctors Mayo" by Clapesattle. Mrs. Walter Klawiter of Kohler sang three selections, "The Old Refrain" by Kreisler, "Shortnin' Bread" by Wolf and "Auralee." She was accompanied by Mrs. Huibregtse.

In the absence of Mrs. H. J. Hansen of Sheboygan Falls, who was in attendance at the meeting of the State Board of Directors in Milwaukee, Mrs. J. W. McRoberts presided.

Walworth

Mrs. T. J. Kroyer, Walworth, and Mrs. J. A. Rawlins, Elkhorn, were appointed philanthropic co-chairmen at the January meeting of the Woman's Auxiliary to the Walworth County Medical Society, reports Mrs. J. D. Warrick, Sharon. After a one o'clock luncheon at the Garden House, Delavan, the members adjourned to the home of Mrs. N. F. Crowe. The president, Mrs. E. D. Sorenson, announced the appointment of Mrs. Crowe as historian, and Mrs. J. H. Young, Elkhorn, as archives chairman.

Winnebago

Dr. Eugenia S. K. Cameron of the Bureau of Maternal and Child Health of the State Board of Health, Madison, was the guest speaker at the January meeting of the Woman's Auxiliary to the Winnebago County Medical Society, reports Mrs. S. R. Beatty, Oshkosh. The meeting was preceded by a luncheon at Stein's.

Dr. Cameron placed emphasis on the fact that public morals in a situation such as the present depend on mental as well as physical health. "Proper direction of the mental growth of the child is apparently a solution to a great part of this problem of deviation from normal adjustment later," she continued. "Development is on the basis of experience; personalities are not fixed but are formed and reformed through life."

"A sound mental hygiene program is needed to prevent severe mental cases," Dr. Cameron pointed out. Child guidance clinics are established in some communities, with psychiatrists, psychologists and social workers to study the problems of children, she reported. Milwaukee has the only one in Wisconsin, but more and more communities are becoming aware of the need for this service in trying to develop clinics.

The Auxiliary held a luncheon meeting on February 16 at the Hotel Raulf, Oshkosh. Following the luncheon the group adjourned to the home of Mrs. C. J. Combs for their regular meeting, and heard Mrs. Combs give an interesting review of the play "The Wookey Family," by Frederick Brennan. She presented an interesting description of the reactions of the British family in the various situations that arise.

Members of the Auxiliary expressed regret at the absence of their president, Mrs. W. N. Linn, because of illness.

ANNUAL MEETING—Hadden Hall will be the headquarters for the annual meeting of the Woman's Auxiliary to the American Medical Association—Atlantic City, New Jersey, June 8 to 12, 1942. Requests for reservations should be sent immediately to Hadden Hall, Atlantic City, New Jersey.

Society Proceedings

Brown—Kewaunee—Door

The regular monthly dinner meeting of the Brown–Kewaunee–Door County Medical Society was held at the Beaumont Hotel, Green Bay, on February 12. Local members conducted a program on civilian defense, in which the discussion was led by Dr. George M. Shinners. An address entitled "Emergency Care" was given by Dr. Lawrence D. Quigley, and Dr. Allan A. Filek spoke on "Public Health."

Members of the Society voted to retain a local attorney for the purpose of defining physicians' rights with regard to the medical care of patients on mothers' pension.

Clark

Members of the Clark County Medical Society held a meeting at the Merchants' Hotel, Neillsville, on January 29, at which Dr. Milton C. Rosekrans of Neillsville was in charge of the program.

Columbia—Marquette—Adams

Fourteen members attended the meeting of the Columbia–Marquette–Adams County Medical Society held at St. Savior's General Hospital, Portage, on February 17. The meeting was devoted to a general discussion of the part to be played by the medical profession in first-aid training.

Dane

The regular monthly meeting of the Dane County Medical Society was held on February 10 at the Madison Club. Dr. Nels A. Hill, Madison, was in charge of the program which was on the subject of cancer and was presented by two doctors from the University of Wisconsin Medical School. Dr. Harold P. Rusch, assistant professor of oncology and research fellow in cancer, spoke on "Cancer Investigations at McArdle Memorial Laboratory" and Dr. Frederic E. Mohs, instructor in surgery and associate in cancer research, discussed "Chemosurgical Treatment of Cancer." The presentations of these papers were followed by discussions by Dr. Edwin F. Schneiders and Dr. William D. Stovall, professor of hygiene at the University of Wisconsin Medical School and director of the State Laboratory of Hygiene.

Dodge

Dr. Alexander G. Hough, Beaver Dam, secretary of the Dodge County Medical Society, recently sent out a notice to the effect that "because of mountains of snow around Dr. Karsten's hilltop home," the January 29 meeting would be held at the Community House, Horicon.

The speaker of the evening was Dr. Elmer L. Sevringhaus of the State of Wisconsin General Hospital. His subject was "The Diagnosis and Treatment of Menopausal Disorders."

Members who attended this meeting reported that an interesting and instructive scientific program was enjoyed. A complete plan of medical defense for the county was organized.

Douglas

Seventeen members of the Douglas County Medical Society were present at the monthly meeting held at Hotel Superior, Superior, on February 4. Two papers comprised the scientific program. Dr. Henry A. Sincock, Superior, presented a paper entitled "Management of the Tuberculous Pregnant Woman", and Dr. Thomas J. Doyle, Superior, spoke on "Otitis Media."

Eau Claire—Dunn—Pepin

Forty-two members attended the dinner meeting of the Eau Claire–Dunn–Pepin County Medical Society at the Eau Claire Hotel on January 26. Lectures by two doctors from the University of Minnesota Medical School comprised the scientific program. Dr. Francis W. Lynch, clinical associate professor of dermatology, spoke on "Recent Advances in Treatment of Skin Diseases" and Dr. N. Logan Leven, clinical assistant professor of surgery, discussed "Treatment of Burns." Members in attendance reported that these lectures were very interesting and instructive.

Green

All Green County Medical Society officers were re-elected for another year at the Society meeting on January 29 at the Monroe Hotel. Those re-named as officers were Dr. Wilson G. Bear, Monroe, president; Dr. Silvain J. A. Francois, New Glarus, vice-president; and Dr. Leurner E. Creasy, Monroe, secretary–treasurer.

Dr. Nathan E. Bear, Monroe, presented a paper on the treatment of wounds, based on recent experiences of various authors. Motion pictures were also shown.

At the business session Dr. M. T. Morrison of South Wayne was elected to membership by transfer from Jefferson County, Missouri. Drs. Fred W. Kundert and Leslie G. Kindschi, both of Monroe, were admitted to membership by transfer from Dane County, at an earlier meeting.

Green Lake—Waushara

Dr. Shirley L. Hadden, founder of the Wild Rose Hospital, was host to members of the Green Lake–Waushara County Medical Society at a dinner meeting at the Hospital on February 17. The guest speaker was Dr. Kenneth E. Lemmer, associate professor of surgery at the University of Wisconsin Medical School, who lectured on "Gallbladder Disease." Mr. Stephen E. Gavin, Jr., Madison, investigator for the Wisconsin State Board of Medical Examiners, discussed the film strip "Health Achievements in Wisconsin."

Seven members attended this meeting, to which members of the Woman's Auxiliary were invited as guests.

Jefferson

The regular monthly meeting of the Jefferson County Medical Society was held at Hotel Carlton, Watertown, on February 19. Following a 6:30 dinner Dr. Theodore C. H. Abelman, Watertown, discussed "Civic Defense." Twenty-seven members were in attendance.

La Crosse

Forty-one members of the La Crosse County Medical Society attended the dinner meeting held at Hotel Stoddard, La Crosse, on February 10. The guest speaker was Dr. Per Hedenius of Stockholm, Sweden, who for the last year has been on an exchange fellowship in the United States and has visited hospitals in Philadelphia, Baltimore, New York, Boston and Chicago relative to his research work on serum protein. The title of Dr. Hedenius' lecture was "Blood Plasma in Shock."

Marinette—Florence

A dinner meeting of the Marinette–Florence County Medical Society was held at the Marinette General Hospital on February 11. Members in attendance enjoyed an interesting address entitled "Appendical Peritonitis" presented by Dr. Earl Garside of Augustana Hospital, Chicago.

Milwaukee

The monthly meeting of the Medical Society of Milwaukee County was held at the Milwaukee Athletic Club on February 13. The guest speaker was Lieutenant Commander Marion B. Sulzberger, M. C., U. S. N., who gave a lecture entitled "Hypersensitivity to Drugs." Dr. Robert E. Fitzgerald discussed "The Procurement and Assignment Service."

At a business session members discussed amendment to the by-laws regarding associate membership. There were 379 members present.

Outagamie

Dr. Everett H. Brooks, Appleton, was host at a special meeting of the Outagamie County Medical Society at his home on February 10. Among those present were Dr. Stephen E. Gavin, Council chairman, State Medical Society; his son, Mr. Stephen E. Gavin, Jr., investigator for the State Board of Medical Examiners, and Mr. Charles H. Crownhart, secretary, State Medical Society. The part the medical profession plays in civilian defense was discussed.

The regular monthly meeting of the Society was held on February 19 at the Conway Hotel, Appleton. Dr. Fred W. Hark, assistant professor of orthopedics, and first assistant to Dr. Henry B. Thomas, University of Illinois College of Medicine, addressed the group on fractures, showing some of the equipment used in the treatment of fractures in the University of Illinois College of Medicine. Dr. R. E. Mutchler, state health supervisor of the National Youth Administration, spoke on the organization's health program.

Polk

Fifteen members of the Polk County Medical Society were guests of Dr. Henry C. Caldwell, St. Croix Falls, at an evening dinner at the St. Croix Inn on January 15. The guest speaker was Dr. William H. Hengstler, St. Paul, who spoke on "Psychiatric Problems of the General Practitioner."

Racine

Dr. Chester M. Kurtz, associate professor of medicine at the University of Wisconsin Medical School, was the guest speaker at the meeting of the Racine County Medical Society at the Elks Club on February 19. The title of Dr. Kurtz' address was "Cardiac Problems Encountered in Everyday Practice and How to Handle Them."

Rock

Dr. Peter C. Kronfeld, medical director of the Illinois Eye and Ear Infirmary, Chicago, presented an illustrated lecture entitled "Five Years at the Pekin Medical College" at the meeting of the Rock County Medical Society at Hotel Hilton, Beloit, on January 27. This was a dinner meeting to which members of the Woman's Auxiliary were invited.

Sauk

The monthly meeting of the Sauk County Medical Society was held on January 23, and the following officers were elected for the year 1942: Drs. Harold A. Bachhuber, Sauk City, president; Ernest L. Jewell, Loganville, vice-president; Thomas W. Walsh, Sauk City, secretary–treasurer; Alba C. Edwards, Baraboo, delegate; and Fitz R. Winslow, Baraboo, alternate delegate.

Shawano

Members of the Shawano County Medical Society held a meeting on January 27 at the Shawano Municipal Hospital. On this occasion the following

were voted into office for the ensuing year: Dr. Earl E. Evenson, Wittenberg, president; Dr. Orville E. Damp, Birnamwood, vice-president; Dr. Frederick Bauer, Shawano, secretary–treasurer; and Dr. Ernest L. Schroeder, Shawano, censor for three years.

Trempealeau—Jackson—Buffalo

The monthly meeting of the Trempealeau–Jackson–Buffalo County Medical Society was held at Independence on February 19, with sixteen members in attendance.

Dr. Gunnar Gundersen, La Crosse, president of the State Medical Society, discussed "State Society Problems," and Dr. Robert L. MacCornack, Whitehall, gave a brief report of his five years' experience as a member of the State Board of Health.

Part of the meeting was devoted to a discussion of the Procurement and Assignment Service.

Dr. Robert W. Utendorfer, Mondovi, was elected to membership in the Society.

Walworth

A symposium on "Medical Civilian Defense" was presented at the dinner meeting of the Walworth County Medical Society held at the Walworth County Hospital at Elkhorn on February 19. Those participating in the symposium were Drs. Charles E. Pechous, Kenosha; Edwin J. Schneller, Racine; Cyril G. Richards, Kenosha; and Edward D. Hudson, Lake Geneva. This meeting, which was a joint meeting with the Auxiliary, was well attended, with forty present.

Washington—Ozaukee

The Washington–Ozaukee County Medical Society meeting was held at St. Alphonsus Hospital, Port Washington, on January 29 at 8 p. m. Dr. Francis B. McMahon, assistant clinical professor of surgery at Marquette University School of Medicine, was the guest speaker. The title of his address was "Cancer of the Stomach." Eleven members attended the meeting.

Winnebago

Dr. Merritt L. Jones, Wausau, was the speaker at the dinner meeting of the Winnebago County Medical Society at the Raulf Hotel, Oshkosh, on February 5. The title of his address was "Peripheral Nerve Injuries."

Plans for the observance of April as cancer control month were discussed at this meeting. Groups or organizations wishing to arrange for speakers on the subject of cancer control during April were invited to make arrangements with Dr. Marcellus C. Haines, Oshkosh, president, or Dr. Earl F. Cummings, Oshkosh, secretary.

Dr. Herman W. Wirka, associate professor of orthopedic surgery at the University of Wisconsin Medical School, was a guest at this meeting.

Wood

Eighteen members of the Wood County Medical Society met at Hotel Witter, Wisconsin Rapids, at 6:30 p. m., on January 29 for a dinner meeting. Included on the scientific program was a symposium on "Lumbar Spine Injuries." Those participating in the symposium were: Drs. Wallace L. Nelson, Leland C. Pomainville, and Rogers E. Garrison, of Wisconsin Rapids, and Harold G. Pomainville and Otto A. Backus, of Nekoosa. Another scientific paper was presented by Dr. Walter G. Sexton, Marshfield, entitled "Renal Tumors."

At a business session the following officers were elected for the year 1942: Dr. Leland C. Pomainville, Wisconsin Rapids, president; Dr. George L. McCormick, Marshfield, vice-president; Dr. Robert W. Mason, Marshfield, secretary–treasurer; Dr. Karl H. Doege, Marshfield, delegate; and Dr. Frank X. Pomainville, Wisconsin Rapids, alternate delegate.

Clinical Society of Genito-Urinary Surgeons

The twenty-second annual meeting of the Clinical Society of Genito-Urinary Surgeons was held in Madison on February 27 and 28. The following program was presented:

FRIDAY

9:00–11:45 a. m. Operative Clinic at the State of Wisconsin General Hospital—Dr. Ira R. Sisk, professor of urology, University of Wisconsin Medical School, and associates

12:15–1:45 p. m. Madison Club, Luncheon and Round-Table Discussion on "Present Status of Chemotherapy"—Dr. William F. Braasch, professor of urology, Mayo Foundation, leader

2:00 p. m. Clinical Discussions, Biochemistry Building, College of Agriculture, with Chris L. Christensen, dean of the College of Agriculture and director of the Agricultural Experiment Station, presiding

"A Bit of Wisconsin Nutrition History"—Edwin B. Hart, professor of biochemistry

"Rickets and Irradiation"—Harry Steenbock, professor of biochemistry

"Pellagra and Nicotinic Acid"—Conrad A. Elvehjem, professor of biochemistry

"Vitamin C and Reproduction"—Paul H. Phillips, professor of biochemistry

"Sweet Clover Disease and Possible Human Relations"—Karl P. Link, professor of biochemistry

General Discussion, followed by a visit to the Biochemistry Research Laboratories

7:00 p. m. Dinner and annual meeting at the home of Dr. and Mrs. Ira R. Sisk

SATURDAY

State of Wisconsin General Hospital

9:00 a.m. to 12:00 Operative Clinic—Dr. Ira R. Sisk and associates

12:30–1:45 p.m. Luncheon and Round-Table Discussion on "Present Status of Hormone Therapy"—Dr. Harry Culver, associate professor of genito-urinary surgery, Northwestern University Medical School, Chicago, leader

2:00 p.m. Clinical Discussions, "Traumatic Rupture of the Kidney"—John B. Wear, associate professor of urology

"The Influence of Vitamin A on Glomerular Function"—Dr. R. C. Herrin, associate professor of psysiology

"Evolution of Anesthesia"—Dr. Ralph M. Waters, professor of anesthesia

"Review of Prostatic Surgery in the State of Wisconsin General Hospital in 1940–41"—Dr. Philip M. Cornwell, resident in urology

"Primary Carcinoma of the Epididymis, Report of a Case" and

"Sarcoma of the Prostate, Report of Two Cases"—Dr. Homer H. Kohler, senior resident in urology

"Treatment of Carcinoma of the Bladder"—Dr. John B. Wear, associate professor of urology

General Discussion

Following are the members of the Clinical Society of Genito-Urinary Surgeons who attended this meeting:

Dr. Nathaniel G. Alcock, Iowa City, Iowa; Dr. William F. Braasch, Rochester, Minn.; Dr. Henry G. Bugbee, New York City; Dr. George F. Cahill, New York City; Dr. John A. C. Colston, Baltimore; Dr. Harry Culver, Chicago; Dr. Clyde H. Deming, New Haven, Conn.; Dr. Homer G. Hamer, Indianapolis; Dr. Charles C. Higgins, Cleveland; Dr. Frank Hinman, San Francisco; Dr. Herman L. Kretschmer, Chicago; Dr. William E. Lower, Cleveland; Dr. Reed M. Nesbit, Ann Arbor, Mich.; Dr. Frank S. Patch, Montreal, Canada; Dr. James T. Priestley, Rochester, Minn.; Dr. Alexander Randall, Philadelphia; Dr. Ira R. Sisk, Madison; Dr. Gilbert J. Thomas, Minneapolis.

Milwaukee Academy of Medicine

Members of the Milwaukee Academy of Medicine held a dinner meeting at the University Club on February 17, which was preceded by a business meeting and scientific program.

Dr. Arthur C. Corcoran of the Eli Lilly & Company laboratory for clinical research at Indianapolis, who was the guest speaker, discussed "Nature and Experimental Treatment of Hypertension."

Drs. Arthur W. Johnson and George H. Hansmann reported on the Academy's milk commission, explaining certified milk and its use.

At the next meeting of the Society to be held on March 17 the guest speaker will be Dr. Edgar S. Gordon, research associate in medicine and assistant professor of physiological chemistry at the University of Wisconsin Medical School. He will speak on "Debunking the Vitamin."

Milwaukee County Hospital Internes' Association

A two-day meeting was held on January 30 and 31 at the Milwaukee County Hospital, Wauwatosa, under the sponsorship of the Milwaukee County Hospital Internes' Association.

Dr. Francis D. Murphy, clinical professor of medicine and director of the Department of Medicine at Marquette University School of Medicine; and Dr. Joseph M. King, associate clinical professor of surgery at Marquette University School of Medicine, gave lectures on Friday and Saturday mornings.

The Friday afternoon session consisted of papers by the following: Drs. Rudolph P. Gingrass; James G. Garland; David J. Werner, clinical instructor in obstetrics and gynecology at Marquette University School of Medicine; and Joseph J. Gramling, Jr., instructor in anatomy at Marquette University School of Medicine, all of Milwaukee, and Dr. Samuel B. Pessin, senior pathologist, State Laboratory of Hygiene, Madison.

On Saturday afternoon the program consisted of two scientific papers by guest speakers. Dr. Nelson W. Barker, associate professor of medicine, Mayo Foundation, Rochester, gave a lecture entitled "Coagulation of Blood." Dr. C. Donald Creevy, professor of surgery, director of division of urology, and assistant dean of the University of Minnesota Medical School, presented a paper entitled "Urology in General Practice."

The meeting concluded with a banquet at the Elks Club, at which Mr. Arch Ward, Chicago sports writer, was the speaker.

Milwaukee Oto-Ophthalmic Society

The regular monthly meeting of the Milwaukee Oto-Ophthalmic Society was held at the University Club on February 10, commencing with a 6:30 dinner. The customary clinical meeting, with presentation of cases, preceded the scientific program.

The guest speaker was Dr. Bayard T. Horton, associate professor of medicine, The Mayo Clinic, Rochester, Minnesota, who spoke on "Histamine in the Treatment of Specific Types of Headaches and in Meniere's Disease." Dr. Theodore L. Squier, Milwaukee, opened the discussion of Dr. Horton's paper.

At a business session Dr. Aubrey H. Pember, Janesville, and Dr. Gerhard D. Straus, Milwaukee, were elected to active membership in the Society.

Milwaukee Pediatric Society

The Milwaukee Pediatric Society held a meeting on February 11 at the Milwaukee Athletic Club.

The program consisted of an illustrated talk by Dr. Moses Cooperstock, Northern Michigan Children's Clinic, Marquette, Michigan, who spoke on "Bronchial Obstruction in Respiratory Tract Infection with Special Reference to Pulmonary Complications. "A short film on homemade mechanical respirators in the 1940 poliomyelitis epidemic was also shown by Dr. Cooperstock.

The April 8 program will consist of a round-table discussion, the subject to be announced later.

Milwaukee Society of Clinical Surgery

Members of the Milwaukee Society of Clinical Surgery held a dinner meeting at the University Club on January 27. Following a business meeting addresses were presented by the retiring president and the president respectively. Dr. R. W. Roethke, Milwaukee, spoke on "Plastic Surgery on the Fallopian Tubes" and Dr. Jerry W. McRoberts, Sheboygan, discussed "Recent Aids to Surgery." The meeting was well attended.

News Items and Personals

St. Nicholas Hospital, Sheboygan, celebrated its golden jubilee and completion of its $500,000 addition with a banquet in Benedict's Heidelberg Club, on February 10. The hospital, which now has a bed capacity of 255, is operated by the Hospital Sisters of St. Francis. On the program which followed the banquet, the medical profession was represented by *Dr. Willard G. Huibregtse*, secretary of the Sheboygan County Medical Society.

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Dr. Arnold S. Jackson, of the Jackson Clinic, Madison, was one of the speakers at the Jackson County Health Forum held in Kansas City, Missouri on February 18. His title was "Goiter, Its Symptoms and Cure."

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Dr. Carl N. Neupert, assistant state health officer, Madison, opened the series of meetings of the government and social welfare department of the Madison League of Women Voters on January 26 at the Madison Free Library, with a discussion of the activities and scope of the State Board of Health.

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Dr. Ronald B. Rogers, Neenah, gave a lecture entitled "The Treatment and Nurse Care in Burns and Skin Grafts" at the third meeting of the refresher course given at Theda Clark Hospital Nurses' Home on February 3. The course is for registered nurses, active and inactive, in the Fox River Valley area and is a part of the national defense program. About 111 nurses are taking the course.

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An iron lung valued at $2,000, built at the Marinette Vocational School at a cost of $400 and financed by the Kiwanis Club of Marinette, was presented to the Marinette General Hospital at a Kiwanis Club meeting on February 4. The presentation was made by Mr. Walter Kirmse, president of the club, and accepting it for the hospital was Mr. C. F. Schroeder, chairman of the hospital board.

Dr. Marcos Fernan–Nunez, professor and director of the Department of Pathology and Bacteriology, and associate professor of public health, Marquette University School of Medicine, was the guest speaker at the annual meeting of the medical staff of St. Mary's Hospital, Duluth, Minnesota, on February 5. His presentation, entitled "A Medical Travelogue on Spanish America," was illustrated with colored lantern slides and motion pictures. In his address *Dr. Fernan–Nunez* predicted that with the return of American soldiers from service in tropical lands tropical diseases may become a problem in medical practice in northern latitudes.

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"Aphasia" was the topic of discussion at the State of Wisconsin General Hospital staff meeting held in the auditorium of Service Memorial Institutes on February 3. State Medical Society members participating in the discussion were *Dr. Mabel G. Masten*, associate professor of neuropsychiatry, and *Dr. Hans H. Reese*, professor of neuropsychiatry.

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Dr. Gail R. Broberg, Neenah, was the guest speaker at the meeting on January 29 of the Lincoln Parent–Teacher Association at Neenah.

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Dr. Roger C. Cantwell, Shawano, discussed "Worry and How It Affects Your Health" at the February meeting of the Shawano Woman's Club. He commented on the fact that the greatest worries and fears are of things which might happen, 80 per cent of which never do occur, and suggested an analysis of such unproductive worrying for better physical and mental health.

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Dr. Edward R. Krumbiegel, city health commissioner of Milwaukee, spoke on nutrition at the Oklahoma Avenue Parent–Teacher Association birthday celebration on February 14.

GEO. V. I. BROWN, M. D.

Dr. George V. I. Brown, internationally known oral and plastic surgeon, was honored on February 15 at a dinner at the Pfister Hotel, Milwaukee, by more than 100 former patients. Tribute was paid the 80-year-old Milwaukee physician in a talk by his rector, the Rev. Holmes Whitmore of St. Paul's Episcopal Church, and by Mr. Lawrence Halpenny, assistant executive of the Milwaukee County Boy Scout Council.

Dr. Brown retired recently from operative practice and is doing consultation work only. His successor in operative practice is *Dr. Volney B. Hyslop*, who also maintains an office in Madison. *Dr. Brown* is noted particularly for his work after World War I in rebuilding the faces of wounded soldiers. During World War I he was called to the Surgeon General's office in Washington, D. C., and made chief of the plastic and oral service at Walter Reed Hospital. Under General Gorgas' orders he established a school for training men in plastic surgery at Fort Oglethorpe, Georgia, before they went overseas. *Dr. Brown* was a major in the Medical Reserve Corps during World War I, and afterward he was in command of the 326th Medical Regiment in Milwaukee. He is now a colonel, inactive.

A graduate of Milwaukee Medical College, he lectured as a professor at the University of Iowa. He was also professor of oral and plastic surgery at the University of Wisconsin from the time the four-year course was started in 1920 until he was retired as emeritus professor in 1937. Other colleges at which he gave special lectures include the University of Illinois, Vanderbilt University, and the University of Tennessee.

Dr. Brown is a member of many national and international medical societies, a number of which have conferred upon him special honors. He was awarded the medal of honor for scientific work by the Italian Physico-Chemical Academy, and in 1921 the Jarvie Gold Medal for oral surgery by a New York society. He is an honorary member of La Societe Belge de Stomatologie, the American Society of Plastic and Reconstructive Surgery, the Milwaukee Academy of Medicine, and the International College of Surgeons. He is a member of the Founders' Group of the American Board of Plastic Surgery.

Among Dr. Brown's numerous valuable contributions to the medical literature is "The Surgery of Oral and Facial Diseases and Malformations, Their Diagnosis and Treatment, Including Plastic Surgical Reconstruction," fourth edition, published by Lea and Febiger, Philadelphia.

WM. D. STOVALL, M. D.

Dr. William D. Stovall, professor of hygiene at the University of Wisconsin Medical School and director of the State Laboratory of Hygiene, spoke on February 24 in St. Paul, Minn., at a state meeting of the Women's Field Army. The title of his address was "Cancer, Its Prevention and Control." *Dr. Stovall* is state chairman for the American Society for the Control of Cancer.

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In behalf of the Committee on Health and Public Instruction of the Society, Mr. George B. Larson, assistant secretary, appeared before the meeting of the Wisconsin Association of Fairs to discuss the availability of the Society's newly developed health exhibit. Secretaries of county fairs throughout Wisconsin attended the meeting.

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Dr. William S. Middleton, professor of medicine and dean of the University of Wisconsin Medical School, discussed "Sulfonamide Drugs" at the annual meeting of the staff of Johnson Emergency Hospital, Milwaukee, on February 5.

A preliminary progress report of work on a new method of treating carbon monoxide poisoning by the administration of oxygen under pressure was described by *Dr. Chester W. Long*, Milwaukee, one of its two originators. He said the new treatment would expel carbon monoxide from the blood stream ten to twenty-five times as fast as the ordinary treatment, under which oxygen is administered at normal pressure. Dr. Long's collaborator in experiments on the new treatment was *Dr. Edgar M. End*, Wauwatosa. *Dr. Edward R. Krumbiegel*, Milwaukee, participated in the discussion.

At a business session the following officers, all of Milwaukee, were re-elected: *Dr. Walter M. Kearns*, president; *Dr. Charles R. Marquardt*, vice-president; Mrs. Edgar Habeck, secretary–treasurer; and *Drs. Walter M. Kearns, Arthur J. Patek*, and *Andrew J. Weber*, censors.

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An informal discussion of the subject of health was presented at the meeting on February 10 of the Oconto Falls Parent–Teacher Association. *Dr. George W. Krahn* showed the State Medical Society film entitled "Health Achievements in Wisconsin."

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Health and nutrition were the subjects under discussion at the regular meeting of the Joint Committee on Education in Wisconsin at the Memorial Union, Madison, on February 18. *Dr. Dorothy McDonald*, advisory physician in school health education, State Board of Health, described the program which she is developing in Wisconsin.

Program For Spring Clinics is Announced by the Council on Scientific Work

THE Council on Scientific Work has secured outstanding faculty members to participate in the Society's annual spring clinics to be held on April 27, 28 and 29. Through the efforts of the Council on Scientific Work and especially through Dr. G. W. Krahn, chairman, Dr. W. L. Palmer, associate professor of medicine at the University of Chicago School of Medicine, has been secured as the internist faculty member. Dr. H. H. Cummings, Ann Arbor, Michigan, will present the obstetrical subjects on the program.

Wisconsin Faculty Members

Wisconsin faculty members include Dr. S. E. Gavin, chairman of the Council, who will act as general chairman and will also present the topic "The Physician in Wartime." Dr. Gavin is serving on the Sixth Corps Area Committee of Procurement and Assignment Service. Dr. W. S. Middleton, dean of the University of Wisconsin Medical School, will discuss medical topics, and Walter Zeit, Ph. D., assistant professor of anatomy at Marquette University School of Medicine, will complete the faculty by presenting short discussions on the anatomy of the body.

S. E. GAVIN, M. D.

Under One Roof

The clinics will be held in Chippewa Falls on April 27, in Wausau on April 28, and in Fond du Lac on April 29. In each community the entire program will be presented under one roof,—in Chippewa Falls at Hotel Northern, in Wausau at Hotel Wausau, and in Fond du Lac at Hotel Retlaw.

The round-table dinner discussions have previously been so popular that the Council on Scientific Work is including this feature in the program again this year. Four such sessions, which embrace the following subjects, are scheduled: Obstetrics and pediatrics, medicine and its newer therapeutics, surgery, and general medicine. In order that there might be free discussion a separate room has been set aside for each group. The round-table dinners will begin at 6:30 p. m.

Manikin Demonstrations

A second popular feature to be repeated this year is the obstetrical manikin demonstrations by Dr. W. C. Keettel, special instructor in obstetrics and gynecology for the Bureau of Maternal and Child Health of the State Board of Health. Individual conferences will be given each member of the Society who wishes to avail himself of this opportunity. As in the round-table dinners, a separate room will be available for physicians' conferences with Dr. Keettel.

Nominal Fee

A registration fee of $5 will be charged for the clinic day. This nominal fee includes dinner with one of the round-table discussion groups, as well as the opportunity to hear throughout the day the outstanding faculty presentations of recent developments in medicine. A registration blank, descriptive folder, and other data will be mailed to each member of the Society late this month. As soon as the registration blank reaches you, make your selection of a clinic center and mail it to the State Medical Society office in Madison.

(Continued on page 252)

The art of doing things well

IN THE Lilly Laboratories not just any cat or frog that happens along is used in standardizing digitalis. Lilly accuracy demands careful selection and housing of test animals under standard conditions in order to avoid individual variations due to environment and nutrition. Frogs which are being prepared for digitalis testing are held in a constant temperature bath where a variation of no more than 0.1° C. is permitted. The results of testing are evaluated by competent workers, some with over twenty years of experience in digitalis standardization.

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1942 Spring Clinic Program

MONDAY, APRIL 27—CHIPPEWA FALLS
TUESDAY, APRIL 28—WAUSAU
WEDNESDAY, APRIL 29—FOND DU LAC

S. E. Gavin
General Chairman

MORNING SESSION

9:30 a. m.–12:15 p. m.

9:00 Registration

9:30 Anatomy of the Female Pelvis
Walter Zeit, Ph. D., assistant professor of anatomy, Marquette University School of Medicine, Milwaukee

9:45 Postpartum Care; Repair of Lacerations and Episiotomy Wounds
H. H. Cummings, Ann Arbor, Michigan

10:15 Functional Colitis
W. L. Palmer, associate professor of medicine, University of Chicago School of Medicine, Chicago, Illinois

10:45 RECESS
Obstetrical Manikin Demonstration —W. C. Keettel, Bureau of Maternal and Child Health, State Board of Health, Madison

11:00 Carcinoma of the Lung
W. S. Middleton, dean and professor of medicine, University of Wisconsin Medical School, Madison

11:30 Postoperative Emergencies

AFTERNOON SESSION

2:00–5:45 p. m.

2:00 Anatomy of Stomach and Gallbladder
Walter Zeit, Ph. D., Milwaukee

2:20 Peptic Ulcer—Medical Management
W. L. Palmer, Chicago, Illinois

3:00 Peptic Ulcer—Surgical Management

3:40 RECESS
Obstetrical Manikin Demonstration
W. C. Keettel, Madison

3:55 Complications of Menopause
H. H. Cummings, Ann Arbor, Michigan

4:35 Treatment of the Critically Ill
W. S. Middleton, Madison

5:15 The Medical Profession and the War
S. E. Gavin, Fond du Lac, committee member, Sixth Corps Area, Office of Assignment and Procurement Service

DINNER ROUND-TABLE DISCUSSIONS

6:30–9:00 p. m.

6:30 Round-Table Dinners
Newer Drugs—W. S. Middleton, Madison
Obstetrics and Pediatrics—H. H. Cummings, Ann Arbor, Michigan; and W. C. Keettel, Madison
Surgery—S. E. Gavin, Fond du Lac; and Walter Zeit, Ph. D., Milwaukee
Gastro-Intestinal Diseases—W. L. Palmer, Chicago, Illinois

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Amniotin A SQUIBB PREPARATION OF ESTROGENIC SUBSTANCES OBTAINED FROM THE URINE OF PREGNANT MARES

50,000 Wisconsin Employers Receive 1942 Compensation Panels

EVERY Wisconsin employer subject to the Workmen's Compensation Act has received the 1942 revision of the Society's panels of physicians for Wisconsin's seventy-one counties. Immediately after release of the panels, the Society's office was deluged with requests from employers for additional copies to place on bulletin boards, in auxiliary buildings, warehouses, washrooms, first-aid stations, and similar locations in industrial plants.

"A Real Choice Should Be Given . . ."

Included with the Society's panels to all Wisconsin employers subject to the Workmen's Compensation Act was a letter from the Industrial Commission over the signature of Mr. Harry A. Nelson, director of the Workmen's Compensation Division. In urging employers to grant choice of physician to injured employes, Mr. Nelson declared, **"When injury has occurred a real choice should be given to the employe of his attending physician. No attempt should be made to persuade or coerce him into accepting the services of a certain physician. Attention should be called to the panel, and the employe should be requested to make his selection without suggestion or comment on the part of the employer, except as requested by the employe."**

HARRY A. NELSON

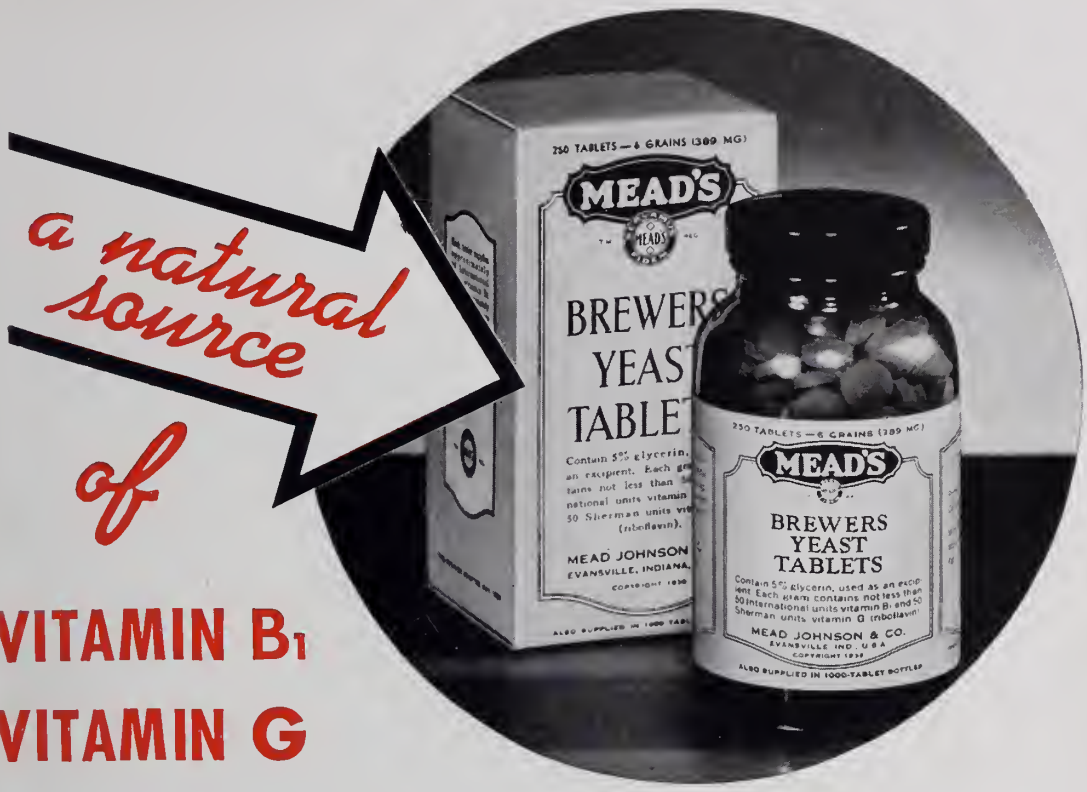
The four years of operation of the open panel agreement have disclosed its great usefulness in giving to employes a wide choice of physician. Studies indicate that many more physicians now are rendering service to injured employes than was the case prior to adoption of the open panel agreement.

"Great Task of Employer Education . . ."

It is conceded, however, that a great task of employer education remains to be filled. There are many employers under the impression that the old statute providing a limited panel of three physicians is still in effect and still others who think the previous law which provided a limited panel of five still remains on the statute books. The Workmen's Compensation Act was revised in 1939 to provide that the employe should be given "reasonable choice" in the selection of his physician. A panel so limited as to give employes a choice of but three to five physicians would not be deemed reasonable in many communities in Wisconsin. The reasonableness of choice of physician is determined by the Industrial Commission on the basis of circumstances in each individual community.

"County Medical Societies to Inform . . ."

While great effort has been and can be made by the State Society to acquaint employers with the open panel agreement, the statutory provisions which provide for reasonable choice, additional efforts can be made by county medical societies to inform employers of the open panel agreement. In communities where it is known that employes are not given reasonable choice of physician and where it is known that the panel provided by the Society is not posted in industrial plants and offices, the county medical society can acquaint employers with the availability of the panel and the operation of the panel agreement. If members of any county medical society would like to have the assistance of the Conference Committee on Open Panels, they may address their request to the State Society office in Madison. County medical societies wishing to have additional copies of the brochure explaining the open panel agreement, which also contains a copy of the agreement, as well as additional copies of the panel for their community, may obtain them by writing the Society's office.



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AMENDED REGULATION ON DISPENSING EXEMPT NARCOTIC PREPARATIONS

Federal regulations have for several years required a dispensing physician, among others, to record all sales, exchanges, gifts, and other disposition of exempt narcotic preparations. The entries are to be made at the time of delivery and must show the name and address of the consumer, the name and quantity of the preparation, and the date of such disposition.

An amendment to the above rule effective February 6, 1942, provided in substance that the above requirement is not merely a condition imposed upon the physicians and others who dispense drugs as a condition of their being allowed to dispense exempt narcotic preparations, but that the keeping of full records as above required is an absolute and independent requirement of law, the violation of which renders the physician or other dispenser subject to the criminal liability provided by the Harrison Narcotic Act.

The amended regulation is intended only to clarify the administrative intention of the U. S. Narcotics Commissioner, and does not create any new liability on the part of the *dispensing* physician, nor does it require the keeping of records of narcotic preparations used by an *attending* physician. The amendment is limited to records required for the dispensing of such exempt narcotic preparations as paregoric and does not change existing regulations as to the dispensing of pure narcotics.

Both prior and subsequent to the above amendment the federal law, which was construed as recently as February 2, 1942, by the U. S. Supreme Court, limited the requirement of keeping of the full records above referred to to *dispensing* physicians and excluded from such requirement "physicians administering to patients whom they personally attend."

For a more detailed discussion see December 1941 Blue Book Issue of *The Journal*, pages 1237 and 1240.

TUBERCULOSIS—FIND IT, TREAT IT, CONQUER IT!

Another Early Diagnosis Campaign will be under way soon. This year the Wisconsin Anti-Tuberculosis Association, with the slogan of "Find It, Treat It, Conquer It," is urging physicians of Wisconsin as a national defense measure to aid in the conquest of tuberculosis. While April is designated as "EDC" month, and the Early Diagnosis Campaign is stressed more during this month, the fight against the White Plague is a year round battle.

During the last twelve years in Wisconsin over 800 families have been found in which there have been two or more deaths from tuberculosis. These families are a particular challenge to the doctor in private practice. Research studies in the majority of these families have shown that by careful examination of the other members, from ten to thirty times as many cases of tuberculosis are ferreted out as are found in the examination of individuals representing a cross section of the population. Continued interest in these families through periodic examination, supervision and guidance is bound to limit the spread of this disease to other families.

We still believe there are between five and ten active cases of tuberculosis for each death in a given area. With 800 deaths reported in Wisconsin in 1940, therefore we have between 7,000 and 10,000 active cases. We should all accept this as a challenge for early recognition of cases, so that proper treatment can be most effective.

Patients with early tuberculosis will recover if they are placed sufficiently long on bed rest in the fresh air, receive nourishing food properly prepared, as well as adequate medical and surgical aid when necessary. After recovery, further intelligent medical supervision leading to complete rehabilitation is necessary. If we add to such interest, careful watching of other members of these families, tuberculosis can be conquered.

A big job? Yes. But if physicians are ever conscious of tuberculosis, seek it where it is, find it as early as possible, and fight it to a finish in each family where it appears, we can and will conquer this enemy and perfect one more national defense measure.

If the W. A. T. A. can be of help to you in finding, treating, or conquering tuberculosis in families under your supervision, we would welcome the opportunity.—A. A. Pleyte, M. D., Medical Department.

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Wisconsin State Board of Medical Examiners

Members of the State Board of Medical Examiners are H. H. Christofferson, M. D., Colby, president; H. W. Shutter, M. D., Milwaukee, secretary; Jessie P. Allen, M. D., Beloit; A. F. Ruffolo, M. D., Kenosha; E. W. Miller, M. D., Milwaukee; R. G. Arveson, M. D., Frederic; C. A. Dawson, M. D., River Falls; and E. C. Murphy, D. O., Eau Claire. This section of The Wisconsin Medical Journal *will appear periodically under the editorship of the secretary of the Wisconsin State Board of Medical Examiners, Dr. H. W. Shutter, to provide the physicians of Wisconsin with current information on activities of the organization.*

The one hundred forty-ninth meeting of the Wisconsin State Board of Medical Examiners was held at Hotel Loraine, Madison, on January 13, 14, and 15, 1942.

There were twenty-six applicants for licensure by examination, and the credentials of fourteen physicians of other states were reviewed and acted upon favorably for reciprocity. There was one revocation of license.

Because of the emergency, the papers of several applicants were examined immediately following the final examination to allow them to qualify for commissions in the Army and Navy. The Board will cooperate to the best of its ability to avoid hardships in communities with a limited number of available practitioners. This may require special meetings interspersed between the semi-annual meetings of the Board.

It was decided to establish reciprocity with the Territory of Alaska. At the present time Wisconsin has reciprocity with all states of the Union with the exception of Massachusetts and Florida.

The question of accepting for licensure diplomates of the National Board of Medical Examiners was considered with Mr. Everett S. Elwood, executive secretary of the National Board of Medical Examiners, who met with us. The matter was laid on the table until the June meeting. As is known, for some time Wisconsin has not accepted graduates of foreign medical schools because of the impossibility of accurately evaluating their credentials. The National Board has now adopted the same policy, and it is possible that at our next meeting we may see fit to accept their licentiates.

One applicant appeared before the Board requesting a certificate in massage and hydrotherapy. For several years the Board has accepted no schools of massage outside the state as the basis of education for licensure in this branch of the healing art. Dr. William J. Egan of Milwaukee, specialist in physical therapy, appeared before the Board, and arrangements were made for the establishment under his direction of a school of massage and hydrotherapy. This will fill a great need in Wisconsin.

Mr. Stephen E. Gavin, Jr., newly appointed investigator for the Board, was present and many matters concerning the enforcement of the Medical Practice Act were considered. Mr. Gavin has held this position only four months and has been familiarizing himself with the many angles of medicolegal work in Wisconsin. A considerable number of complaints are now under investigation, most of which are concerned chiefly with licensed and unlicensed chiropractors and optometrists. Several advertising quacks and physicians are also under investigation, and one or two persons advertising the cure of cancer are presently to be brought before the courts of justice. As soon as possible, violators whose cases require court action will be brought to trial.

The newly elected secretary of the State Medical Society, Mr. Charles H. Crownhart, met with the Board and kindly offered the help and cooperation of his office in all matters in which it could aid. This includes files on violators of the Medical Practice Act. It was suggested that from time to time *The Wisconsin Medical Journal* publish material prepared by the Board so that physicians throughout the state may be kept more closely informed as to its activities.

The Board wishes to place before the physicians of the state the fact that the re-establishment of the enforcement feature of the Medical Practice Act will be a slow one. A new system of filing is being set up in the office of the secretary, and a new routine of investigating complaints is now in force. This, we are sure, will be more effective in

accomplishing the results we know are expected. A routine has been established whereby all original complaints must come to the office of the secretary for proper classification and investigation. A committee, comprised of Drs. Christofferson, Miller, and Shutter, has been appointed by the Board to consider all complaints and place those warranting action in the hands of the investigator.

—H. W. SHUTTER, *Secretary.*

Fight Cancer, Conquer Fear, Delay, and Ignorance

Pointing out that "total war demands that every man and woman do more, not less," Dr. Thomas Parran, Surgeon General of the United States Public Health Service, has written the American Society for the Control of Cancer saying, "It is my earnest hope that no smallest gain along the public health front be lost in our patriotic response to the demands of total war. This means that we must not let down in our service to humanity, but must make greater sacrifices, find more time for emergency service. The Women's Field Army is one of our advance guards. We look to it to hold the line."

Dr. C. C. Little, managing director of the American Society for the Control of Cancer states, "In reaching any decision as to orientation of the cancer control program to wartime demands, certain definite principles must be borne in mind by all of us.

"First, we must remember that the cancer problem is continuous and vital. . . The menace of cancer must be met by uninterrupted volunteer efforts. . .

"Second, we must realize that in many cases the noise and glamour of war activities create a misleading sense of their importance and permanency.

"Third, we, in keeping with general advice from our Government, urge that all war activities assumed by any member of the Women's Field Army shall be in addition to, rather than in the place of, cancer control efforts. This war must be won while the framework of the peace to follow is maintained, not neglected.

"Fourth, we feel that care must be taken to avoid the mistaken philosophy that we can abandon continuing public health problems and responsibilities during the war and expect to resume them successfully at its close."

The Women's Field Army personnel, together with you, the physician members of the Medical Society, must work together to win this war on cancer. With enlistment from April 6 to May 12, we go forward in our sixth year with courage high and the determination to make 1942 the best year in the history of the volunteer army FIGHTING CANCER,—fighting to win against fear, ignorance, and delay.—Mrs. G. E. STODDART, *State Commander.*

APRIL
27
28
29

Circle
The Dates

and

plan to attend

the Annual

Spring
Postgraduate
Clinics

Chippewa Falls April 27
Hotel Northern

Wausau April 28
Hotel Wausau

Fond du Lac April 29
Hotel Retlaw

Turn To . . .

page 250 for
complete details

Technical Exhibitors Reserve Space For the One Hundred First Anniversary Meeting in Milwaukee, September 14, 15 and 16

TECHNICAL exhibitors received on Monday, January 26, the floor plan of exhibit space available at the One Hundred First Anniversary Meeting of the State Medical Society of Wisconsin. Reservations by telephone and telegraph on Monday and Tuesday and the days immediately following reserved all of the available exhibit space.

The firms who have reserved exhibit space are as follows:

A. S. Aloe Company
The Borden Company
Camel Cigarettes
Cameron Heartometer Company
S. H. Camp & Company
Carnation Company
Conformal Footwear Company
R. B. Davis Company
DePuy Manufacturing Company
Eli Lilly & Company
H. G. Fischer & Co., Inc.
General Electric X-Ray Corp.
Gerber Products Company
H. J. Heinz Company
Horlick's Malted Milk Corp.
Hurley X-Ray Company
"The Junket Folks"
E. H. Karrer Company
Kelley–Koett Company
Kellogg Company
Kremers–Urban Company
Lakeside Laboratories, Inc.
J. B. Lippincott Company
Mead Johnson & Company
Medical Protective Company
Mellin's Food Company
Mennen Company
Merck & Co., Inc.
C. V. Mosby Company
V. Mueller & Company
Parke, Davis & Company
Pet Milk Sales Corp.
Petrogalar Laboratories, Inc.
Philip Morris & Company, Ltd.
Photoart House
Physicians and Hospitals Supply Co., Inc.
Roemer Drug Co.
W. B. Saunders Company
Scanlan–Morris Company
Schering Corp.
Sharp & Dohme, Inc.
Smith, Kline & French Laboratories
E. R. Squibb & Sons
U. S. Hospital Supply Company
Westinghouse X-Ray Division
White Laboratories, Inc.
Winthrop Chemical Company, Inc.
John Wyeth & Brother, Inc.

W. L. Palmer, M. D., associate professor of medicine, University of Chicago School of Medicine, Chicago

. . . Will Discuss . . .

"FUNCTIONAL COLITIS"
"PEPTIC ULCER—MEDICAL MANAGEMENT"
"GASTRO-INTESTINAL DISEASES"

At the following centers:

Chippewa Falls, April 27—Wausau, April 28—Fond du Lac, April 29

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A Statement by

RIGGS OPTICAL COMPANY

To Our Customers, Our Competitors and Our Country

As each new year begins it has been our custom to plan and precast a program of purpose and activity. In past years the program has been built around sales quotas, efficiency and production records as they related to dollar profits.

But this year the Riggs Optical Company put aside this custom, doing so and knowing well that in 1941 it experienced the best year in its history.

Our country is at war. We know that to many of our customers and our competitors and to ourselves that will mean sorrow . . . suffering . . . sacrifice. There can be no such thing as normal business in times of war. And we are at war, a war only for victory—whatever the cost.

Recognizing these facts, we pledge ourselves, every man and woman of us, and our business with its background of thirty-five years of existence, to the devotion of our every energy to all-out effort for victory.

If such an effort sometimes slows our services or results in unintentional errors or even eliminates profits—well, that's what war may do to the best of friends and business relationships.

You'll know, however, that we are always doing the best we can to help you give your patients the best vision possible for the victory job they have before them.

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with

The Scientific Advancements

in

Obstetrics
Surgery
Medicine
The Physician In War

at the

Spring
Postgraduate
Clinics

Chippewa Falls April 27
Wausau April 28
Fond du Lac April 29

Turn To . . .

page 250 for
information on
speakers and subjects

THE PRESS

*Health and Wisconsin products:** Attention is called to a current series of articles appearing in the *Wisconsin Medical Journal,* official publication of the Wisconsin State Medical society, Madison, on the importance of Wisconsin products to the health of the nation. In view of the increased emphasis on health standards in time of war these articles would be of special interest in high school courses touching upon matters of nutrition.

The first article of the series appears in the January issue of the *Medical Journal.* It is written by Dean Chris L. Christensen, dean of the U. of W. College of Agriculture, and is entitled "Butter in National Health." Other articles of a like nature will appear in future issues, and reprints will be available as soon as the series is completed. Send in your name and address to the State Medical society, Tenney Bldg., Madison, and request that your name be added to the mailing list for reprints.

* Reprinted from *Wisconsin Journal of Education,* February, 1942.

CORRESPONDENCE

Correction

February 11, 1942

The State Medical Society of Wisconsin
917 Tenney Building
Madison, Wisconsin
Dear Sirs:

I wish to correct an error in the article entitled "A Pyrexia Test: Differentiation of 'Functional' Fever From That of Infectious Origin" published in *The Wisconsin Medical Journal* in January 1942. The statement in the paragraph entitled "The Pyrexia Test" which states "The patient is first given a series of four 3/5 gr. doses of one of the coal tar antipyretics" is to be corrected to 3 to 5 grs.

Besides the references cited in the text the original principle of this test may also be found in Feer's "Diagnosis of Children's Diseases; With Special Attention to the Diseases of Infancy," translated by C. A. Scherer, ed. 1, revised. Philadelphia, J. B. Lippincott Company, 1925.

Additional references pertaining to the publication are:

(Continued on page 264)

Benzedrine Sulfate in Mild Depressions

THE PHYSICIAN in general practice, as well as the specialist, encounters many patients suffering from mild depressions. With such patients, there is ample evidence in the literature that Benzedrine Sulfate therapy will often produce some or all of the following effects:

(a) Increased mental activity and interest.

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(c) Psychomotor stimulation; increased interest, motor activity and accessibility.

(d) Increased feeling of energy and alertness; increased capacity for physical and mental effort.

In many patients, depression may occur as an accompaniment of some more fundamental pathology, either organic or psychogenic. In such cases, the physician should bear in mind that while Benzedrine Sulfate will not affect the underlying condition, its stimulatory effects may help to alleviate the depression which so often interferes with the management of the case. It is primarily useful in depressions characterized by apathy and psychomotor retardation, but is contraindicated in patients manifesting anxiety.

Benzedrine Sulfate Tablets

Brand of amphetamine sulfate

The use of Benzedrine Sulfate by normals should not be permitted; it should always be administered under the careful supervision of a physician; and depressive psychopathic cases should be institutionalized.

In treating depressed patients with Benzedrine Sulfate, the physician should bear in mind that any drug which produces pleasant or euphoric effects may prove to be habit forming—especially in unstable or neurotic individuals.

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Bazett, H. C.: Physiological Responses to Heat, Physiol. Rev. 7:531–587, 1927.
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Deutsch, F.: Treatment of Post-infectious Fever with Single Large Doses of Amidophrin, Unverricht. Med. Wchnschr. 57:1456–1457 (Aug. 21) 1931.
Feer, E.: Movement Hyperthermia and Constitutional Hyperthermia: Growth Fever, Klin. Wchnschr. 10:1241–1244 (July 4) 1931, abstracted in J. A. M. A. 97:1041 (Oct. 8) 1931.
Pinkston, J. O., Bard, Philip, and Rioch, D. M.: The Responses to Changes in Environmental Temperature after Removal of Portions of the Forebrain, Am. J. Physiol. 109:515–531, 1934.
Ranson, S. W., and Clark, George: Neurogenic Fever Reduced by Nembutal, Proc. Soc. Exper. Biol. & Med. 39:453–455 (Dec.) 1938.
Reimann, H. A.: Habitual Hyperthermia: A Clinical Study of Four Cases with Long Continued Low Grade Fever, Arch. Int. Med. 55:792–808 (May) 1935.
Sollman, Torald: A Manual of Pharmacology and its Applications to Therapeutics and Toxicology, ed. 5, Philadelphia, W. B. Saunders Company, 1936.
Starling's Principles of Human Physiology, ed. 7, edited and revised by C. Lovatt Evans, with chapters on Central Nervous System and Sense Organs revised by H. Hartridge. Philadelphia, Lea & Febiger, 1936.
Taylor, H. M., and Dyrenforth, L. Y.: Chilling of the Body Surfaces; Its Relationship to Aural and Sinus Infections, J. A. M. A. 111:1744–1746, 1938.
Wiggers, C. J.: Physiology in Health and Disease, ed. 3, Philadelphia, Lea & Febiger, 1939.

Sincerely yours,
Signed: M. J. FOX, M. D.

January 28, 1942.

Miss Lucia Stolp
Wisconsin Medical Journal
917 Tenney Bldg.
Madison, Wisconsin

Dear Miss Stolp:

Our mutual friend, Andrew W. Hopkins, has advised me that we have your permission to use Dean Christensen's article in an early issue of *National Butter & Cheese Journal.* We will give the *Wisconsin Medical Journal* due credit, and when it is printed, we will send a copy of the paper to you.

Thank you very much.

Yours very truly,
NATIONAL BUTTER & CHEESE JOURNAL
EDWARD K. SLATER, *Editor.*

Lederle Laboratories have announced the availability of a booklet entitled "Abstracts Selected from Published Articles on Sulfadiazine."

This booklet is available through Lederle representatives or on request, from Lederle Laboratories, Inc., 30 Rockefeller Plaza, New York, N. Y.

Additional information on Sulfadiazine appears on page 194.

This Booklet Will Be Sent To You On Request

THIS new booklet on "The Laryngoscope as a Diagnostic Aid for the General Practitioner" is intended as an aid in the recognition of common laryngeal diseases. It will be sent to you on request, without obligation to you. Of course, this is not a complete treatise on laryngeal examination, but we believe that the material will aid any practicing physician in making a laryngeal examination. Request your copy from the Instrument Division, American Optical Company, Southbridge, Massachusetts.

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Literature on Request

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BIRTHS

A son, David Smith, to Dr. and Mrs. Hart E. Van Riper, Silver Springs, Maryland, on January 28.

A daughter, Joanne Dorothy, to Dr. and Mrs. Anthony R. Curreri, Madison, on February 12.

A son to Dr. and Mrs. J. W. Laird, Jr., Appleton, on January 26.

MARRIAGES

Dr. John J. Kane, Prairie du Chien, and Miss Florence Plondke, at Prairie du Chien, on January 30.

DEATHS

Dr. Franklin H. Hagerman, Milwaukee, died at a Milwaukee hospital on February 1, at the age of 80.

Dr. Hagerman, who was born in 1861 in Hagermans Corners, Ontario, Canada, came to Milwaukee shortly after receiving his medical degree at University of Toronto Faculty of Medicine in 1892. He had practiced medicine in Milwaukee for the last fifty years.

Surviving him are nieces and nephews in Canada.

Dr. Hagerman held membership in the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Dr. Allen R. Taylor, Brodhead, died at his home of a heart attack on February 13, at the age of 73.

Dr. Taylor was born in Meadon Lee, Manitoba, Canada, on January 15, 1869, and came to the United States in 1899. That same year he received his medical degree from the Milwaukee Medical College, and established his practice at Thiensville, Wisconsin. He had practiced at Brodhead since 1918. Dr. Taylor was a former member of the Green County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow, one son, Edgar, of Brodhead; and two brothers, Leroy of Saskatchewan and Gardner of Manitoba.

Dr. William P. Collins, Racine, at the age of 82, died at his winter home in Lakeland, Florida, on February 7.

Dr. Collins was born near Madison on March 10, 1859. After graduation from the University of Wisconsin in 1882 he attended Rush Medical College in Chicago, from which he received his M. D. degree in 1888. After a few years of medical practice in rural areas Dr. Collins opened an office in Racine, where he practiced medicine until his retirement in 1934. He was a former member of the Racine County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow, a daughter, Mrs. Sidney Warren of Kenilworth, Illinois; two sons, Paul of Haines City, Florida, and William K. of Racine; a grandson; two granddaughters; and two brothers, Edward and Richard, both of Minneapolis.

Dr. Lewis G. Nolte died at his home in Milwaukee on February 15, at the age of 79.

He was born in Milwaukee on December 18, 1862. His medical education was obtained at the College of Physicians and Surgeons of Columbia University, from which he received his medical degree in 1886. Returning to his native city after graduation, he became the assistant to the late Dr. Nicholas Senn. In 1891, when Dr. Senn left Milwaukee to become head professor of the surgical department of Rush Medical College, Dr. Nolte succeeded him in his practice. He maintained this office until his death, and although he had given up the active practice of surgery, he went daily to his office and worked in his laboratory and received patients. His office was reminiscent of another age, with horse hair sofas, engravings and "the first x-ray machine in the west."

Dr. Nolte was at one time a police surgeon. After Johnston Emergency Hospital was founded he served as surgeon and trustee of that institution. For ten years he was chief surgeon at Evangelical Deaconess Hospital and the old Trinity Hospital. He was professor of surgery at Milwaukee Medical College and its successor, Marquette University School of Medicine, for twenty-five years.

In his early practice his conveyance for making calls was the horse and buggy. For many years he kept seven horses, and his coachman sat outside his office, ready for emergency calls. When automobiles first came out he tried an electric one, but did not like it. He never owned a gasoline operated automobile.

Dr. Nolte was a past-president of the Medical Society of Milwaukee County, of which he was a member. He was a life member of the State Medical Society of Wisconsin, and a Fellow of the American Medical Association. He also was a member of the Tri-State, Northwestern, and Brainard Medical Societies, and the American Association for the Ad-

(Continued on page 268)

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* *J.A.M.A., 93:1110, Oct. 12, 1929*
Bruckner, Die Biochemie des Tabaks, 1936
** *The Military Surgeon, Vol. 89, No. 1, p. 7, July, 1941*

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vancement of Science. He was a Fellow of the American College of Surgeons.

Surviving him are his widow, two sons, Louis P. of Milwaukee and William L. of Los Angeles; two sisters, Mrs. Louise Thuering and Mrs. Alvina Matthieson, and a brother Simon, all of Milwaukee.

Dr. George Mathes, Kiel, died on February 19 after several weeks' illness. He was 69 years of age.

Dr. Mathes was born August 21, 1872 in the town of Russell. His high school education was obtained at Plymouth, after which he was graduated from the Oshkosh Normal in 1899. After teaching school in his home district for several years he attended the University of Wisconsin and pursued his course of medical studies in St. Louis and Chicago, graduating in 1904 from the Chicago Homeopathic Medical College. For a short time thereafter he resided in Elkhart before establishing his practice at Kiel, where he remained until his death.

Dr. Mathes had been city health officer at Kiel since 1900, which position he had resigned just prior to his death.

Surviving him are two children, Philip of Kiel and Mrs. Herbert B. Roth of Atlanta, Georgia; a sister, Louisa, of the town of Russell; and a grandson.

Dr. Martin D. Goldenberg, at the age of 44, died at his home of a heart attack, on February 19.

Dr. Goldenberg, who was born in Russia, came to Milwaukee to attend Marquette University School of Medicine, from which he was graduated in 1929. Since that time he had been practicing medicine in Milwaukee.

Surviving him besides his widow are two daughters, Beverly and Velma; three brothers, Misha, Camp Grant, Illinois, and Andrew and Melvin; and a sister, Mrs. Charlotte Goldberg, New York City.

COMING EVENTS

University of Wisconsin Medical School Schedule of Saturday Morning Clinics

Mar. 14. Otolaryngology: Treatment of Common Disorders of the Respiratory Tract. Dr. W. M. Nesbit and Associates

Mar. 21. Obstetrics and Gynecology: Some Common Complications of the Puerperium. Dr. Thornton and Associates

Mar. 28. Medicine: Clinical Course of Minimal Pulmonary Tuberculous Lesions.

Apr. 4. Otolaryngology: Common Office Procedures in the Practice of Ear, Nose and Throat. Dr. M. E. Nesbit and Associates

Apr. 11. Pediatrics: Pitfalls in Infant Feeding. Dr. Tenney and Associates

Apr. 18. Surgery: Surgical Diseases of the Rectum. Dr. Lemmer and Associates

—△—

Milwaukee Children's Hospital—Schedule of Clinical Presentations

The staff of the Milwaukee Children's Hospital has arranged a schedule of clinical presentations for the coming months. A tentative partial program follows. The time of the clinical presentations will be from 12:30 to 1:30 p.m. Dr. Arthur A. Schaefer will direct the surgical clinics, Dr. Walter P. Blount the fracture service clinics, and Dr. A. L. Kastner the pediatric clinics.

MARCH

Pediatric Clinic, Friday, March 13
Diabetes. Discussion by G. F. Kelly, M. D., Milwaukee

Surgical Clinic, Monday, March 16
Presentation of Cases. Discussion of Pericarditis —Suppurative and Adhesive

Fracture Service Clinic, Tuesday, March 17
Out-patient Clinic

Pediatric Clinic, Friday, March 20
Newer Vitamins of the B-Complex. Discussion by L. E. Booher, Ph. D., Milwaukee

Surgical Clinic, Monday, March 23
Presentation of Cases. Discussion of Empyema

Fracture Service Clinic, Tuesday, March 24
Out-patient Clinic

Pediatric Clinic, Wednesday, March 25
Ancient Processes in a Scientific Age. Discussion by C. Anderson Aldrich, M. D., Chicago

Surgical Clinic, Monday, March 30
Presentation of Cases. Discussion of Treatment of Superficial Infection

Fracture Service Clinic, Tuesday, March 31
Out-patient Clinic

APRIL

Pediatric Clinic, Friday, April 3
No Clinic.

Surgical Clinic, Monday, April 6
Presentation of Cases. Kidney Tumors and G. U. Tract Anomalies. Discussion by N. W. Bourne, M. D., Milwaukee

(Continued on page 270)

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Fracture Service Clinic, Tuesday, April 7
Out-patient Clinic

Pediatric Clinic, Friday, April 10
Ascorbic Acid in Human Metabolism. Discussion by L. E. Booher, Ph. D., Milwaukee

Surgical Clinic, Monday, April 13
Presentation of Cases. Discussion of Hernia—Inguinal and Umbilical

Fracture Service Clinic, Tuesday, April 14
Out-patient Clinic

Pediatric Clinic, Friday, April 17
Electroencephalogram. Discussion by Niels L. Low, M. D., Milwaukee

—△—

Wisconsin Trudeau Society

The next meeting of the Wisconsin Trudeau Society will be held on June 12 and 13 at the Four Seasons Club near Pembine, Wisconsin. The meeting will be combined with that of the Michigan Trudeau Society.

Membership in the Wisconsin Trudeau Society is open to all physicians interested in chest diseases. Any physician can have his name included on the mailing list by sending $1 to the secretary-treasurer, Dr. J. D. Steele, 324 East Wisconsin Avenue, Milwaukee. Dues are used to defray expenses of guest speakers and mailing and are collected only when the treasury becomes depleted (as it is at the present time).

SOCIETY RECORDS

New Members

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J. S. Giffin, Summit Hospital, Oconomowoc.

A. L. Martin, Vaughn Building, Ashland.

G. W. Harrison, Knight Hotel Building, Ashland.

E. E. McCandless, Birnamwood.

H. M. Klopf, Bonduel.

E. J. Nagoda, Lake View Sanatorium, Madison.

E. J. Nelson, Sun Prairie.

D. J. Twohig, Jr., 11 North Main Street, Fond du Lac.

P. P. M. Jorgensen, 625 Fifty-seventh Street, Kenosha.

Changes in Address

Lieutenant R. K. Peterson (j. g.), Washington, D. C., to B. O. Q. 600, Pensacola, Fla.

M. H. Seevers, Madison, to Department of Pharmacology, University of Michigan Medical School, Ann Arbor, Michigan.

L. M. Cox, New Orleans, La., to United Fruit Company, Pier #9, North River, N. Y.

F. J. Erdlitz, Milwaukee, to 187 Main Street, Oshkosh.

R. J. Reuter, Milwaukee, to 16 South Henry Street, Madison.

H. V. Malin, Thorp, to 755 North Ashland Avenue, Chicago, Ill.

F. A. Fike, Reedsburg, to 3410 Monroe Street, Madison.

G. W. Malin, La Crosse, to 500 Harvard Street, S. E., Minneapolis, Minn.

L. V. Bergstrom, Rupert, Ida., to Milltown.

L. O. Helmes, Appleton, to 84 Jefferson Avenue, Oshkosh.

Captain E. C. Kocovsky, Camp Grant, Ill., to 1627 Corps Area Service Unit, Scott Field, Ill.

Captain E. W. Vetter, Camp Shelby, Miss., to Co. E, 135th Medical Regiment, A. P. O. 1117, % Postmaster, San Francisco, Calif.

Major Forrester Raine, Camp Grant, Ill., to 147th General Hospital, A. P. O. 1104, San Francisco, Calif.

R. W. Beck, Mendota, to Sacred Heart Sanitarium, Milwaukee.

N. M. Wilson, Reedsville, to U. S. Veterans Hospital, Hines, Ill.

Lieutenant K. D. Hannan, Fort McClellan, Ala., to Companies H and S, 102nd Medical Regiment, 27th Division, A. P. O. 27, Fort Ord, Calif.

H. E. Fillbach, Cuba City, to Monroe.

Lieutenant L. F. Kaiser, Fort Sam Houston, Tex., to M. C., 5th Medical Supply Depot, Ford Ord, Calif.

A. E. Dillman, Soldiers Grove, to Steuben.

R. C. Darby, Red Granite, to Mishicot.

L. M. Morse, Milwaukee, to Billings Memorial Hospital, Chicago.

REYNOLDS—VEGETABLES ARE VITAL

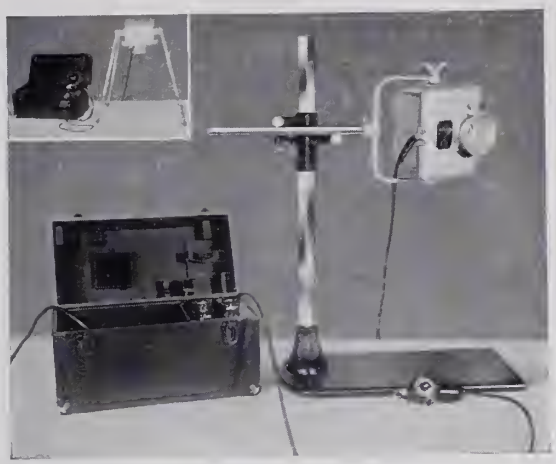
(Continued from page 226)

soon came further studies which revealed that almost all of the vitamin content of food is retained in canning. The original mistake came about in this way:

The component parts of vitamin B, which was later broken down to include thiamin, riboflavin, and nicotinic acid as well as other minor vitamins, are soluble in water. That means that in the cooking process the vitamins are dissolved in the vegetable juices. Consequently, when analyses were made of the vegetables themselves, without the vegetable juices being studied, the cooked product was weak in the B-complex vitamins.

Later, when more complete tests were made, they revealed that thiamin, though it disintegrates when subjected to prolonged heat, can survive short cooking easily. Nicotinic acid, which is less important in most vegetables but available in fair amounts in peas and beans, is hardly affected at all by heat. But in both cases the vitamin dissolves in the juice, and appears more readily there

(Continued on page 272)



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than in the vegetable itself. The accessory food substance which was first called vitamin G, later classified as a B-complex vitamin and called B_2, and finally given the proper name of riboflavin, also dissolves in water and so appears in the juices of cooked vegetables more than in the solid food.

As for vitamin C, succeeding studies showed that cooking in the presence of air destroys that vitamin. So canners got around the problem by first sealing and then cooking tomatoes, cabbage and other vegetables rich in vitamin C.

Cautious Canning Retains Food Values

In the final balance, then, canned vegetables are substantially as efficient sources of vitamins as the original fresh foods; however two cautions must be remembered. The juice of cooked vegetables should always be served with the vegetables themselves or saved to be used in vegetable soups, to retain B-complex vitamins. Tomatoes and the other vitamin C vegetables should be served cold when possible, because reheating of canned foods of this class has a destructive effect on vitamin content. The addition of soda in cooking vegetables should be avoided, because vitamin C deteriorates more rapidly in an alkaline solution.

But fresh or canned, vegetables are tremendously important in the diet. They deserve a place alongside such stand-bys as milk, butter, cheese, fruits, eggs, and meats.

Menu Planning

The final word in menu planning, in light of these facts, is this:

Everyone should get at least a serving a day of leafy green or yellow vegetables, a daily helping of potatoes, and a serving of tomatoes, cabbage or other source of vitamin C.

Any well-balanced diet must recognize the importance of vegetables, for they have their place on every menu.

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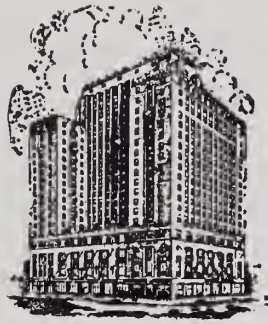

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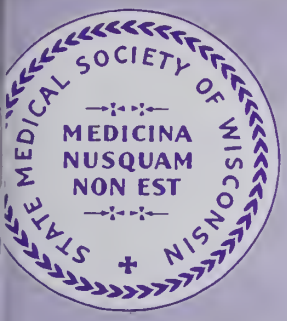

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The Wisconsin Medical Journal

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[Entered as second class matter, June 30th, 1903, at the Post Office at Milwaukee, Wis., under Act of Congress March 3rd, 1879. Transferred to Madison, Aug. 1st, 1929.]
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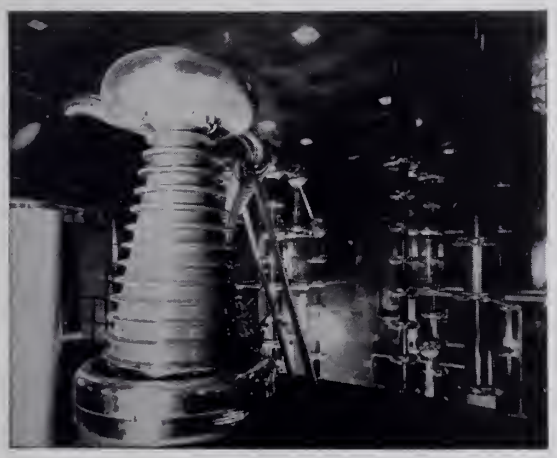

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(1) 1939. Agr. Expt. Sta. Univ. Wisconsin, Bul. 444.
1939. Univ. Maryland Agr. Expt. Sta. Bul. 425.
1937. U. S. Dept. Agr. Farmers Bul. 1253.
1937. Univ. Illinois Agr. Expt. Sta. and Extension Service in Agr. and Home Econ. Circular 472.
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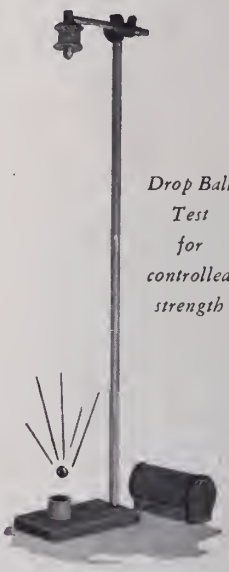

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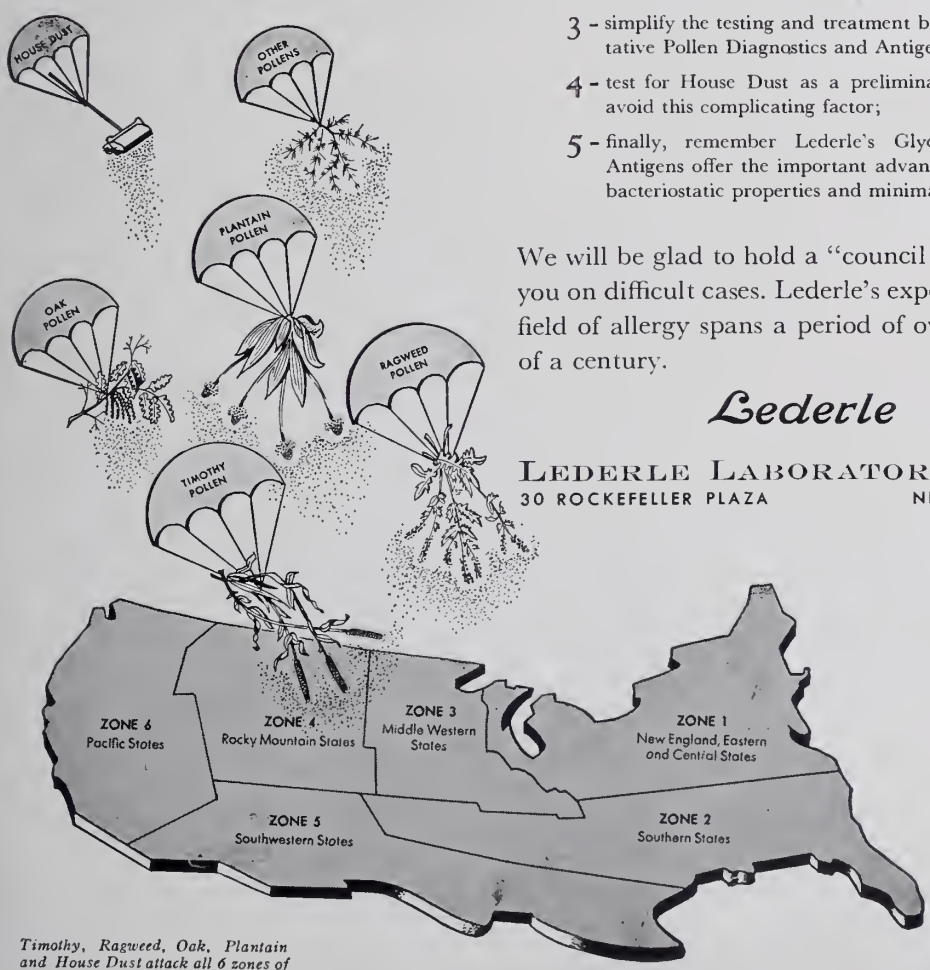

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THE WISCONSIN MEDICAL JOURNAL

VOLUME 41, NO. 4 Copyright, 1942, by The State Medical Society of Wisconsin APRIL, 1942

Cardiac Emergencies and Their Management*

By JAMES A. EVANS, M. D.**

Boston, Massachusetts

AS I LOOK back on my years in the practice of internal medicine, cardiac emergencies fall naturally into two general categories, those seen in the hospital and those seen outside the hospital. In my experience, the order of frequency of emergencies in the home is: (1) acute pulmonary edema, (2) coronary infarction, (3) paroxysmal tachycardia, (4) nocturnal dyspnea of left ventricular failure, (5) heart block, and (6) carotid sinus syndrome.

Also, I should like to list certain circulatory and pulmonary emergencies met more commonly in hospital practice, not strictly cardiac in origin but certainly involving the heart's function: (1) peripheral vascular collapse in infectious diseases, (2) postoperative and posttraumatic shock, (3) pulmonary embolism, (4) massive pulmonary atelectasis, and (5) thyroid crisis.

I shall not attempt to discuss thoroughly the treatment of each of these conditions, but because of limitations of time shall mention out of my experience only certain helpful methods of management.

Acute Pulmonary Edema

I am certain I have been called out hurriedly more often for acute pulmonary edema than for any other acute cardiac emergency. By far the most of these attacks have been due to acute left ventricular failure of the hypertensive heart. More rarely, acute pulmonary edema is due to silent infarction, or perhaps more strictly speaking, to coronary failure. The prognosis in the latter condition is more serious. The diagnosis can be suspected from the history and a more profound drop in blood pressure, but it should be confirmed later by electrocardiogram.

The emergency treatment in the two conditions is the same. First, place the patient in an upright position, although usually he has instinctively assumed it. Secondly, tie a tourniquet about each of the four limbs, although not tightly enough to obliterate the arterial pulses. Thus the volume of blood returning to the right heart is decreased, which has the effect of a temporary phlebotomy. When the patient has recovered, remove the tourniquets one at a time, allowing a judicious time interval after each removal. Thirdly, give him an injection of ¼ grain of morphine sulfate plus at least 1/100 grain of atropine; if the patient is large, give him 1/50 grain of atropine. Do not be content with the usual small dose of 1/150 grain.

The quick bleeding of 500 cc. of blood may be necessary if recovery does not take place. In the hospital, another measure advocated by Barach[1] may be carried out with benefit; namely, inhalation of oxygen and helium under 8 cm. of water pressure, in a closed anesthesia circuit machine. In an emergency, I have used a metabolism machine, with a small weight on top of the bell, for carrying out this treatment. When the patient is in the hospital, plain oxygen can be supplied, preferably by tent or nasal catheter. In the home, I have called in the fire department with its pulmotor apparatus, but I shall never recover from the shock I received when I heard the fire siren and saw the crowd collect. Fifty per cent sucrose solution, 200 to 300 cc. given intravenously,

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* Presented at the Centennial Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

** Department of Internal Medicine, The Lahey Clinic.

and 3 ounces of concentrated magnesium sulfate solution per rectum, to be retained as long as possible, may be used to dehydrate the lung.

Coronary Infarction

In the case of coronary infarction, the physician is called to the home primarily to stop pain. The usual dose of ¼ grain of morphine sulfate hypodermically is often notoriously inadequate. One method I have not seen fail is the intravenous injection of ¼ grain of morphine sulfate dissolved in 10 cc. of 25 per cent magnesium sulfate supplied in ampule. Lately I have been using papaverine intravenously in ½ grain ampules (Eli Lilly). Theoretically, papaverine is supposed to dilate the reflexly spastic arteries which are apt to exist throughout the whole coronary bed when infarction occurs. De Takats[2] has preached much of the dilating effect of papaverine on spastic arteries, and I am sure I have felt a non-pulsating dorsalis pedis artery pulsate soon after papaverine was given for phlegmasia alba dolens of sudden onset associated with reflex arterial spasm.

Another aid for the relief of pain from coronary occlusion is oxygen administered preferably by nasal catheter or tent. In the country I have gone into a garage, borrowed an oxygen tank used for welding, together with the reducing valve such an outfit always carries; prepared a bubbling bottle at the local drug store, heating the glass tubes over the druggist's Bunsen burner; borrowed rubber tubing from an enema bag; used a small urethral catheter for the nasal catheter, and given oxygen intranasally as effectively as by any expensive outfit.

Never forget that with no exception, if dyspnea and cyanosis are present in any cardiac emergency, you cannot hurt your patient with oxygen. Get it to him if you possibly can. I had a doctor friend who, when he went fishing, used to take with him a small tank of helium and oxygen with a rubber hose attachment, because it gave the most relief from nocturnal dyspnea and attacks of pulmonary edema due to a failing left ventricle in Libman–Sachs syndrome of lupus erythematosus.

In coronary infarction the shocklike picture may be treated by applying warmth to the limbs. Raising the blood pressure with adrenalin is to be condemned. Although I have never been convinced that coramine is of much avail, I do use it, 3 cc. at a time, three to four hours apart.

The arrhythmias which may occur during the emergency period of a coronary infarct must be carefully distinguished. The most common is paroxysmal ventricular tachycardia with its danger of swinging into ventricular fibrillation and death. Levine[3] has advocated quinidine to stop this grave disorder, although I have never had the opportunity to use it in a coronary accident. The technic of its dosage will be discussed later.

Auricular fibrillation is the next most common arrhythmia after infarction. Unless the circulation has been embarrassed, I am inclined to let it go untreated rather than insult an injured myocardium with a myocardial toxin. If congestive failure sets in, accompanied by auricular fibrillation, by all means give digitalis—carefully, and not by the massive dose method. It is better to take a week to digitalize the patient fully.

In case of a complete heart block after infarction, with slow, characteristic idiopathic ventricular rhythm, one is inclined to leave the heart in complete block until the infarct has healed, when it may disappear.

The use of aminophylline is to be condemned in the early emergency stage of infarction, because dilatation of the coronary arteries may increase hemorrhage and the area of infarction. What the injured myocardium needs most are glycogen and oxygen. The glycogen may be built up by giving 50 per cent glucose intravenously in 100 cc. doses two to three times daily. Larger amounts of fluid may overload precarious circulatory hydrodynamics.

Extrasystoles and dropped beats due to partial heart block after infarction are very common. They may cause no special concern and will disappear with improvement of myocardial nutrition.

Paroxysmal Tachycardia

Paroxysmal tachycardia, it seems to me, is the third most common cause for emer-

gency house calls. A regular rate of 180 to 200 suggests the diagnosis of paroxysmal auricular tachycardia. Auricular tachycardia cannot be told from ventricular tachycardia except by electrocardiogram, but a neurotic background always suggests the less serious auricular variety. A slower regular pulse of 160 suggests auricular flutter with a 2:1 block. Vagus pressure over the carotid sheath, vagus stimulation by pressure on the eyeball, gagging, and assuming the knee-chest position, may stop auricular or ventricular tachycardia entirely but will only slow auricular flutter. Mecholyl, 0.025 Gm. intramuscularly, should be tried next. It acts as a strong parasympathetic stimulant to slow the heart. Quinidine by the Weisman method will usually stop a persistent paroxysmal tachycardia, auricular or ventricular in origin. This technic involves the administration of 0.2 Gm. of quinidine every hour for five doses unless the pulse slows sooner. If this dosage is unsuccessful after a wait of four to six hours, a double dose is administered. I have several times given intravenously 0.2 Gm. of quinidine dissolved by heating in 25 cc. of saline, acidified with 2 drops of 0.1 normal hydrochloric acid, and filtered through cotton. This experiment with the patient in the electrodes of an electrocardiograph is one of the most dramatic experiences in the field of internal medicine. I have watched the flickering shadow of the galvanometer wire suddenly stop its delirium and assume a steady rhythm and rate of 80 as the drug was slowly injected.

Auricular flutter will not respond to quinidine, but digitalis in adequate dosage will first swing the heart into auricular fibrillation, after which the rhythm will become regular again.

Heart Block

A rarer arrhythmia emergency is the Adams–Stokes syndrome of complete heart block. To rank as an emergency, the cardiac asystole must have lasted long enough to cause fainting. This requires a cardiac standstill of about four to eight seconds. Fifteen seconds will produce a convulsion. By the time the doctor arrives, the emergency is usually over unless the block keeps shuttling from sinus to ventricular rhythm, producing successive faints or a constant state of coma. If a rate of 30 to 40 is found on examination, the diagnosis is easy but often by the time the doctor arrives it can only be suspected, the rate having gone back to normal. In other words, a transient heart block produced the emergency. These patients are usually elderly and arteriosclerotic, and have fainted before in similar fashion. If the patient is doing well on the slow rate it may be better judgment to leave him on it; indeed, to digitalize him to increase the block and keep his heart at the slower rate. We must realize that the faint occurs when the faster sinus rate is blocked and an interval occurs before the ventricle picks up its own intrinsic slower rhythm of between 30 and 40, and not on the opposite shift from slow to normal. However, if the patient is too faint and weak on the slow rate, stimulation may be necessary, and in such instances the best emergency measure is injection of adrenalin intramuscularly or intravenously, 0.5 cc. if hypertension exists, and perhaps 1 cc. otherwise. Aminophylline, given intravenously for a quick effect, may dilate the coronary arteries enough to reoxygenate the conduction pathway, restoring normal sinus control. The best dosage is the 7½ grain ampule. As mentioned before, a shuttling heart block may produce long frightening periods of asystole, with the patient actually turning livid in death. One night I brought such a patient back to life three times by the injection of 1 cc. of adrenalin into the heart, with restoration of a rapid regular pulse, only to see the patient revert into complete block or asystole, finally failing to respond the fourth time. The technic is simple. Use the fourth interspace just to the left of the sternum and insert a 3 inch needle boldly, and when blood can be withdrawn freely into the syringe, inject 1 cc. of adrenalin.

Nocturnal Dyspnea

Sometimes we are called out for nocturnal dyspnea, which is a symptom of left ventricular failure and only a degree short of acute pulmonary edema, being due to the same mechanism. The background is usually

coronary or myocardial failure in a hypertensive patient. Nitroglycerin, grain 1/200, often relieves such an attack and sometimes a drink of brandy or whiskey at bedtime produces enough vasodilatation during the night to prevent its occurrence. And, of course, morphine, pantopon, or codeine are old stand-bys.

Carotid Sinus Syndrome

Let us not forget the carotid sinus syndrome as a rare form of faint. To make this diagnosis we must be "carotid sinus conscious" and think of it when a vagotonic, or neurovascular asthenic, or arteriosclerotic hypertensive type of person is subject to numerous faints. The diagnosis is made by massage over the carotid sinus which reproduces the faint, lowers the blood pressure, sometimes only slows the heart rate, or produces a transient asystole which frightens the observer with his hand on the pulse. The use of atropine in physiologic doses best dulls this reflex. The patient must be warned to wear a loose collar.

These, then, are the most common cardiac emergencies encountered in calling practice. Time permits only a few high-light suggestions in the treatment of what I will call circulatory emergencies in the hospital or at the sick bed.

Peripheral Circulatory Collapse in Infectious Diseases

Our own, the beloved, late Dr. Louis Warfield used to talk a great deal about peripheral circulatory collapse in the acute infections. This is a clinical picture similar to surgical shock, only brought about more slowly and not so easily reversible. It is often the end picture, with cyanosis, cold extremities, rapid feeble pulse, low blood pressure and shallow respiration. It should be treated as is shock, by transfusion, glucose intravenously to restore available circulating blood volume, oxygen to combat cyanosis, and coramine, caffeine or strychnine as stimulants. In pneumonia, oxygen is now our chief reliance against cardiac emergencies, pushing digitalis far in the background unless actual auricular fibrillation occurs.

Postoperative and Posttraumatic Shock

For the treatment of shock, either surgical, posttraumatic, or infectious, one so often sees digitalis used in our hospitals, usually hypodermically, in one ampule doses. This is utter folly. The peripheral circulation is failing, not the heart; available circulating blood volume is decreased, diastolic filling of the heart is inadequate, and peripheral blood pressure has fallen. These are not the indications for digitalis. Fill up the vascular bed, restore its volume, transfuse with blood, glucose, saline, blood plasma, or acacia solution, but preferably with blood or plasma. Blood is the cheapest, but plasma the safest if there is no time for typing. I have never been quite convinced whether coramine is of value, but it does seem sometimes to raise the blood pressure transiently. In these emergencies I like to give it intravenously, 3 cc. at a time. Adrenocortical extract, 3 cc. to 10 cc., in the transfusion jug is preferable to adrenalin. The latter may cause increased loss of fluid from the vascular bed after the initial rise of blood pressure and thus increase the fundamental mechanism of shock.

Pulmonary Embolism

In pulmonary embolism, use papaverine, grain ½ intravenously. It dilates the reflexly spastic pulmonary arterial tree. Oxygen must be used immediately. Then later, if the patient has survived, ligate the femoral artery in the leg in which the thrombus has formed to block another embolism. If the embolism has come from the pelvic veins, heparinize for ten days to be safe, allowing the patient to be up and about in a chair the last two days with the heparin still flowing. I think interns should be taught to go through a surgical or obstetrical ward daily, looking for Homans' sign of pain in the calf on dorsiflexing the foot in all fat women who have had gallbladder operations, hysterectomies or herniotomies. Thus the dangerous phlebothromboses of the calf venous plexuses which are so apt to cause pulmonary emboli would be detected.

Massive Pulmonary Atelectasis

In postoperative massive pulmonary collapse there is so often a picture of sudden

dyspnea, cyanosis, rapid feeble pulse, and drop in blood pressure that a sudden cardiac collapse is suspected by the unwary. In such a postoperative picture, always start out by locating the position of the heart. Heart sounds heard loud up under the lateral third of either clavicle with decreased expansion and suppressed breath sounds on that same side confirm the diagnosis. I am especially anxious to bring this subject up since I believe firmly in Dr. Lahey's mission of preaching early tracheal aspiration in these emergencies. It does much to prevent postoperative pneumonia morbidity and immediately restores the patient to comfort. An anesthetist or nose and throat specialist should be trained and ready to meet this emergency in every hospital of the land.

Thyroid Crisis

In thyroid crisis both the heart and liver have been depleted of their precious glycogen supply, the source of their energy. The treatment indicated is 5 per cent glucose given intravenously, by constant drip if need be, to which has been added Lugol's solution so that the latter is administered at the rate of 4 cc. every six hours. Such a heart is often in auricular fibrillation, but quinidine need not be resorted to unless the fibrillation persists after reduction of thyrotoxicosis by Lugol's solution, or persists longer than three days after operation.

Summary

It will be noted how little digitalis is concerned in the management of acute cardiac emergencies. Newer knowledge of the mechanics of the circulation and physiology of the heart now guides us better. Advances in oxygen therapy, aspiration therapy, anticoagulant drugs such as heparin, glucose given intravenously, adrenalin, aminophylline, and mecholyl, have each in their place a more rational indication.

It is to be noted that the left ventricle is more largely concerned with acute cardiac emergencies, and right ventricular failure with its peripheral congestive phenomenon being a more gradual process as a rule, is therefore out of the scope of this paper.

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A Report on Cesarean Sections and Hospital Deliveries Occurring in Wisconsin—1934 to 1940, Inclusive*

By WILLIAM C. KEETTEL, M. D.
Obstetrical Consultant, Wisconsin State Board of Health, Madison

DURING the last twenty years a concerted effort has been made by the medical profession and the state departments of health to improve maternal care. The fruits of this effort were not immediately apparent; however, in the last eight years there has been a general reduction in maternal deaths. Since increased hospitalization of obstetrical patients and increased operative incidence, especially cesarean sections, have been frequently mentioned as possible obstetrical hazards, it was felt a study of these factors might be of value. For this reason we are presenting an analysis of cesarean sections and hospital deliveries which occurred in Wisconsin during the years 1934 to 1940, inclusive. A second paper, which will appear in the May issue of *The Wisconsin Medical Journal*, will deal with 200 deaths associated with cesarean section during the same period.

Source of Data

In 1937** a questionnaire was sent to the 219 hospitals and maternity homes then licensed by the Wisconsin State Board of Health, asking the number of cesarean sections performed during the years 1934, 1935 and 1936. Ninety-five per cent of these questionnaires were returned. The eleven hospitals which failed to reply were small institutions delivering a small number of patients. A second questionnaire was sent in 1940, asking the number of cesarean sections and hospital deliveries performed during the years 1937, 1938 and 1939. From these 225 hospitals licensed for obstetrical work, there was a 100 per cent return. The 1940 data were obtained directly from the new birth certificates.

Since many hospitals serve a wide area, they base their reports on recorded figures which include resident and nonresident cases. Therefore, in this study state recorded figures were used. Total deliveries in all instances include both live births and stillbirths.

Hospital Facilities

Hospital facilities in Wisconsin have increased constantly. By 1940, Ozaukee,* Calumet, Waushara and Iron were the only counties in the state that had no hospitals. Three counties had only maternity homes—Florence, Sawyer and Washburn. On a whole, these counties with poor or no hospital facilities were in sparsely settled areas, and in most instances there were hospitals in nearby counties.

Many of these smaller hospitals and maternity homes have but a short existence. For example, during the period 1934 through 1936, there were in operation 10 hospitals and 30 maternity homes which did not operate during the next three years. During the years 1937 to 1940, there were 12 new hospitals and 21 maternity homes opened.

Hospital Deliveries

Wisconsin, as shown in Table 1, has had a marked increase in hospital deliveries (including maternity home deliveries). During 1934 to 1940, the percentages of total hospital deliveries increased from 30.6 to 64.4. Counties varied markedly and, as one would expect, the rural, less populated areas with low per capita income had the lowest number of hospital deliveries, while the more populated areas and those near medical centers showed a higher per cent of hospitalization. The nine counties showing less than 20 per cent hospital deliveries were Adams, Clark, Florence, Marquette, Sawyer, Taylor,

* Presented at the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

** Dr. Samuel Bowman Harper, now serving a fellowship at the Mayo Clinic, has kindly permitted the use of this material.

* Hospital established in 1941.

Vernon, Vilas and Washburn. In contrast, Racine County showed 90.2 per cent hospital deliveries, the highest in the state, and Eau Claire 86.3 per cent. Eight other counties (Ashland, Brown, Dane, Douglas, Kenosha, La Crosse, Milwaukee and Sheboygan) showed over 70 per cent hospital deliveries.

Maternity Home Deliveries. — As mentioned, 3 counties had all their hospital deliveries in maternity homes. In the remaining 27 counties having such homes, only about 10 per cent of the hospital deliveries occurred in them. The number of total deliveries occurring in maternity homes was small, varying from 559 to 732 deliveries per year. These accounted for less than 2.0 per cent of the total deliveries.

Registered and Non-Registered Hospitals. —Hospitals not registered by the American Medical Association's Council on Medical Education and Hospitals handled only 3.4 per cent of the total deliveries. Ninety-five per cent of all the hospital deliveries and 98 per cent of all the operative obstetrical procedures were performed in the 135 registered hospitals. Any improvement in hospital care, equipment and standards would necessarily have to be centered in these registered hospitals, since they handle the majority of the hospital deliveries.

Incidence of Cesarean Section Per Total Deliveries

There are two ways of representing the incidence of cesarean sections, one is in terms of the total deliveries, the other in terms of hospital deliveries. Hospital statistics are the most commonly quoted, and these necessarily show a higher incidence of section, since hospitals usually care for more complicated cases. The general opinion is that quoting the incidence of cesarean sections in relation to the total deliveries is a much fairer way of representing section incidence.

De Normandie[3,4,5] who made a study of the cesarean sections performed in Massachusetts during 1922, found the incidence to be 1.28 per cent, or a ratio of 1 section out of 78 deliveries. In 1937 he found the incidence was 3.3 per cent, and in 1938 it had risen to 3.48 per cent. Plass,[11] reviewing sections done in the state of Iowa in 1930, 1931 and 1932, found they constituted 1 per cent of all deliveries in the state. Lynch,[8] studying 12,955 cesarean sections, found that they occurred in 2.5 per cent of the cases. Adair,[1] quoting statistical material from the city of Philadelphia, gave the incidence of sections as 1.78 per cent. Irving,[7] in 1937 reviewed the reports of sixteen authors and adding his own series, found the incidence of sections to be 2.2 per cent, or a ratio of 1 in 45.

In the seven-year period studied there were 383,277 total deliveries in Wisconsin, with 7,729 cesarean sections, an incidence of 2.02 per cent. This gives a ratio of 1 cesarean section for every 49 deliveries. During this period there has been a steady increase in the incidence of cesarean sections, as is shown in Table 1. In 1934, the incidence was 1.64 per cent, or a ratio of 1 in 61. By 1940, the incidence was 2.56 per cent, or a ratio of 1 in 39. During this seven-year period, the total deliveries have increased 6 per cent, while cesarean sections have increased 65.8 per cent.

TABLE 1.—ANALYSIS OF CESAREAN SECTION AND ASSOCIATED DEATHS
(Wisconsin 1934 to 1940, Inclusive)

Year	Total Deliveries	Per Cent Hospital Deliveries	Number of Cesarean Sections	Deaths Associated With Section	Per Cent Section Incidence	Section Ratio	Per Cent Section Mortality
1934	52,932	30.6	868	28	1.64	1 in 61	3.23
1935	53,794	35.1	925	36	1.72	1 in 58	3.89
1936	53,891	39.3	1,022	33	1.90	1 in 53	3.23
1937	55,022	52.7	1,021	35	1.85	1 in 54	3.43
1938	56,213	56.9	1,233	19	2.19	1 in 46	1.54
1939	55,315	60.7	1,221	27	2.21	1 in 45	2.21
1940	56,110	64.4	1,439	32	2.56	1 in 39	2.22
Total	383,277	48.8	7,729	210	2.02	1 in 49	2.72

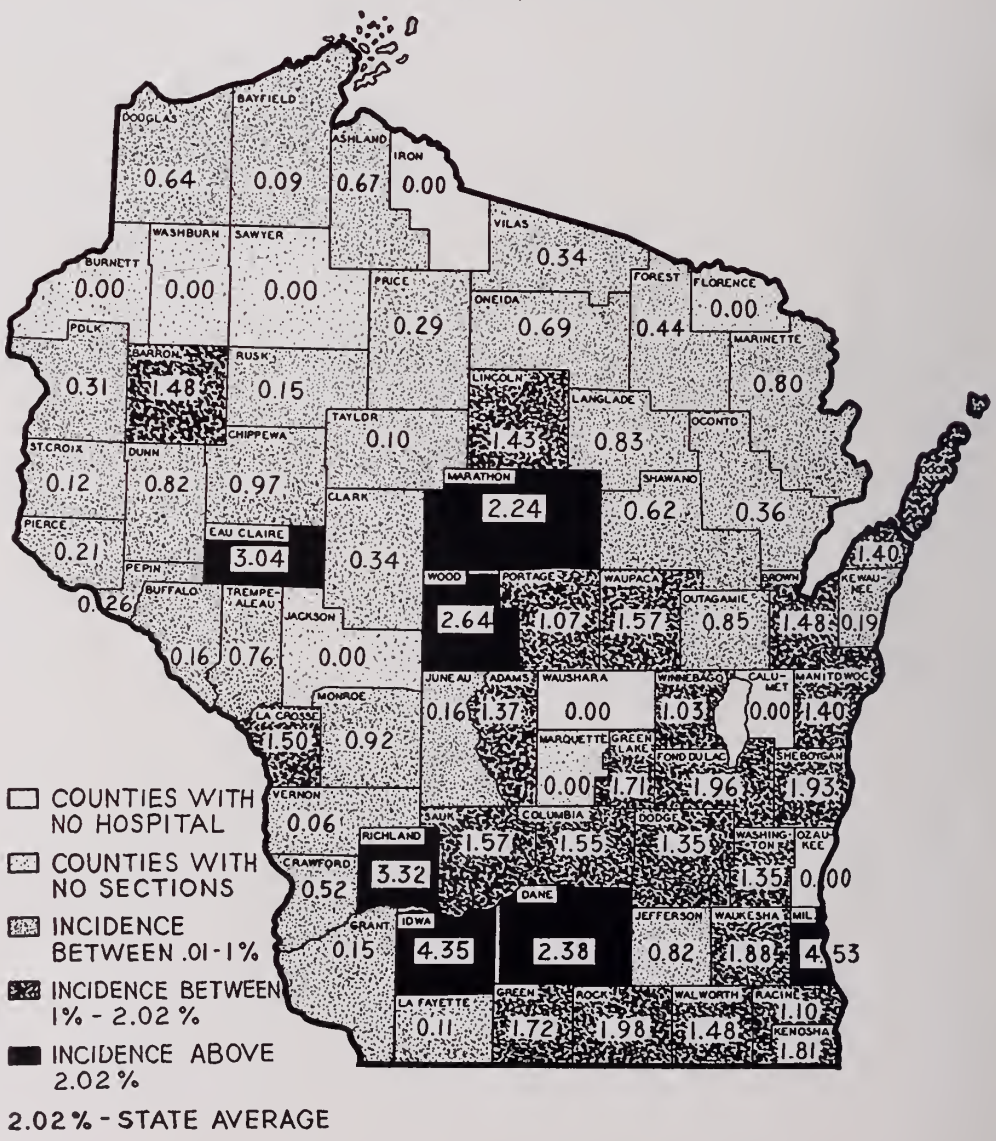
Figure 1 shows the incidence of cesarean sections per total deliveries in the various counties for the seven-year period. The question may be raised that areas which are large medical centers have a higher section incidence from the recorded figures, since they handle more complicated cases. In order to demonstrate that this was not the case, let us use Milwaukee County as an example. In 1940, there were 677 resident cesarean sections out of 11,897 total resident births. The resident section incidence was 5.7 per cent, while the recorded section incidence for the same year was 5.8 per cent.

Cesarean Section Incidence Per Hospital Delivery

Plass,[10] in compiling data for the White House Conference in 1931, received com-

Figure 1

INCIDENCE OF CESAREAN SECTION BY INDIVIDUAL WISCONSIN COUNTIES 1934 TO 1940, INCLUSIVE



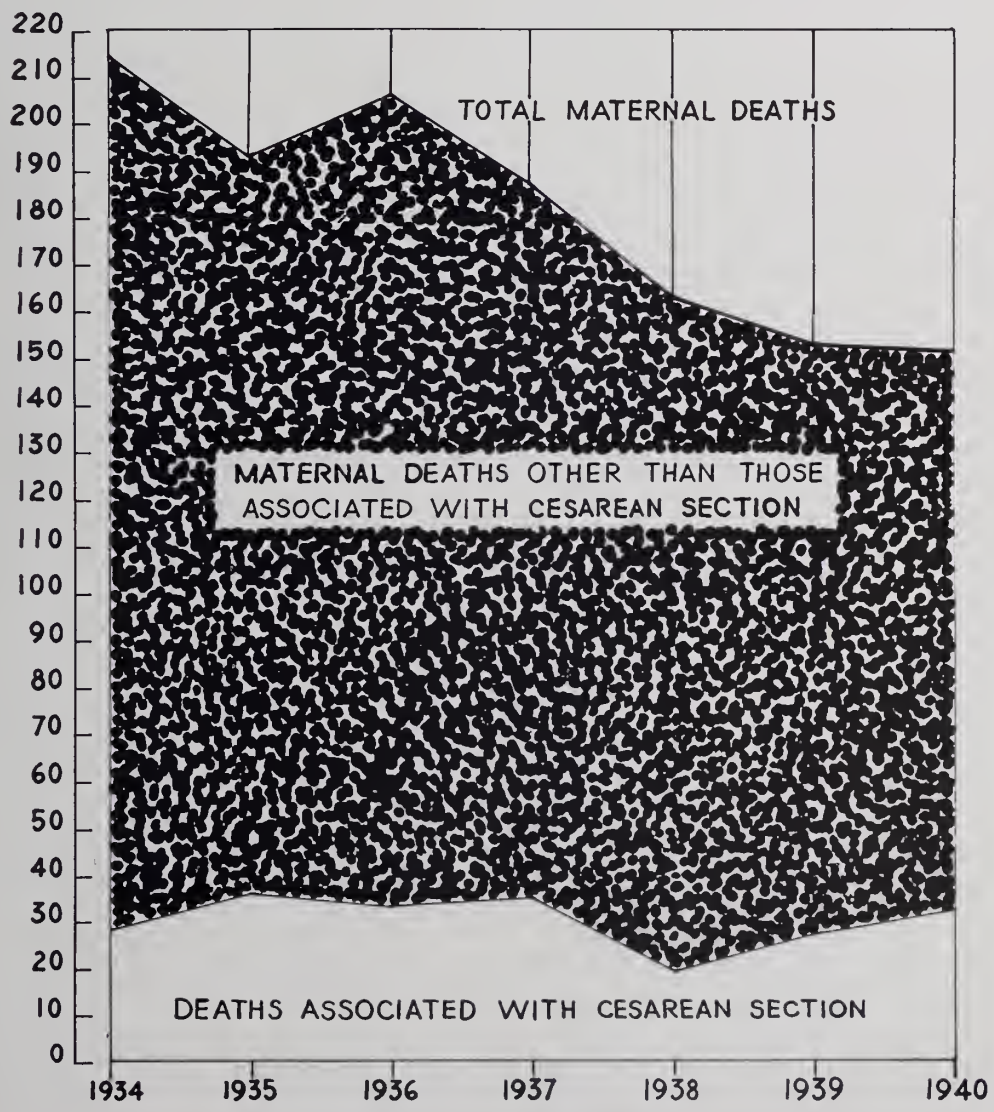
pleted questionnaires from 119 hospitals. For this group of hospitals the incidence of section was 2.9 per cent. This incidence varied among the reporting hospitals from a fraction of 1 per cent to 14.6 per cent. Miller's[9] report from the Hartford General Hospital showed an incidence of 4 per cent for the years 1921 to 1926.

Hawks[6] demonstrated variation in the percentage of ward patients and private patients delivered by cesarean section. In 11,640 deliveries on ward cases the incidence was 1.2, while on 7,515 private patients, the incidence was 3.8 per cent.

Wisconsin has accurate data concerning hospital deliveries for the three-year period,

Figure 2

TOTAL MATERNAL DEATHS AND DEATHS ASSOCIATED WITH CESAREAN SECTION



1937 through 1939. In this period, 94,535 hospital deliveries occurred, of which 3,475 were sections, or an incidence of 3.7 per cent. Hospitals varied considerably — some rates were a fraction of 1 per cent, while others were as high as 23 per cent. Incidence of section in different hospitals in the same community would often vary 20 per cent, showing the individual variation in the handling of obstetrical complications. It is interesting to note that the two teaching hospitals connected with the medical schools showed a rather low incidence of sections despite the fact they handled a high percentage of complicated cases.

Mortality From Cesarean Section

Irving[7] gave the mortality from cesarean section as 5.63 per cent in 12,763 deliveries. In Lynch's[8] series the mortality was 4.1 per cent. Figures as low as 1 per cent mortality have been reported by the Chicago Lying-In Hospital. Plass,[10] however, in his extensive analysis placed the average death rate following cesarean section between 5 and 10 per cent.

Of the 7,729 sections done in the seven-year period in Wisconsin, there were 210 deaths. This gives a cesarean section mortality of 2.72 per cent. As we look at the cesarean death rate from year to year, as shown in Table 1, we notice that it is decreasing. In 1934, the mortality was 3.23 and by 1940 it was 2.2 per cent.

This decrease may be due in part to better operative technique, but an important factor is also that we have broadened our indications for section and at the present time perform more elective sections which are of the less serious type. This conclusion may be drawn from the fact that the counties which do few elective sections have a very low section incidence, but a higher section mortality, while the counties in which more elective sections are done have a lower mortality in spite of the higher incidence of sections.

By studying Figure 2, we note that there has been a steady drop in total maternal deaths. Actually 64 fewer maternal deaths occurred in 1940 than in 1934. This change has undoubtedly been brought about by improved prenatal care, better care during labor, and improved methods in handling puerperal infections. On the other hand, maternal deaths associated with section have changed very little during this same period. Thus, as maternal deaths have decreased, deaths associated with cesarean section have increased in relative importance.

In 1915, 2.5 per cent of the Wisconsin maternal deaths were associated with cesarean section. Despite the fact that these figures must be considered as provisional due to the differences in recording vital statistics, it does show how infrequently sections were done at that time. In 1934, 13.2 per cent of the maternal deaths were associated

TABLE 2.—SHOWING PER CENT OF TOTAL DELIVERIES AND CESAREAN SECTIONS DONE IN VARIOUS GROUPS OF COUNTIES OVER A SEVEN-YEAR PERIOD ARRANGED ACCORDING TO INCIDENCE OF SECTION

Counties	Classification	Per Cent of Total Delivery	Per Cent of Total Cesarean Sections	Mortality From Cesarean Sections	Per Cent of Total Section Deaths
4	Counties with no hospitals	1.3	0.0	0.0	0.0
6	Counties with hospitals No cesarean sections	2.1	0.0	0.0	0.0
31	Counties with Section Incidence of .01 to 1 per cent	27.4	7.2	4.86	13.5
23	Counties with section Incidence of 1 to 2.02 per cent	34.6	26.4	3.48	34.3
7	Counties with section Incidence over 2.02 per cent (over state average)	34.5	66.4	2.11	52.2
71		100.0	100.0	State Average 2.72	100.0

with cesarean sections, and by 1940 it had increased to 21.2 per cent. Other regions of the country also show a high association between cesarean section and maternal deaths. In Lynch's[8] study for seven Pacific Coast cities, cesarean section was associated with 33 per cent of the maternal deaths.

Table 2 shows the per cent of total deliveries and cesarean sections done in the various counties over this period, arranged according to the incidence of section. The 4 counties with no hospitals had 1.33 per cent of the total deliveries. Six counties with hospitals—Burnett, Florence, Jackson, Marquette, Sawyer and Washburn—had 2.1 per cent of the total deliveries, but no sections. However, in all but 2 counties the percentages of hospital deliveries was low.

Thirty-one counties showed a cesarean section incidence under 1 per cent. These counties had 27.4 per cent of the total deliveries during the seven-year period, but only 7.2 per cent of the total sections. The section mortality in this group was 4.86 per cent. The majority of these counties are in the rural group and have a smaller number of hospital deliveries. At the same time it is interesting to note that Ashland, Douglas, Outagamie, Monroe and Jefferson, counties with medical centers, have rates under 1 per cent for the seven-year period.

Twenty-three counties showed a cesarean section incidence between 1 per cent and 2.02 per cent (which is the state average). These counties handled 34.6 per cent of the total deliveries, but did only 26.4 per cent of all the sections. The mortality was 3.5 per cent.

Seven counties had a cesarean section incidence higher than the state average. These 7 counties include Milwaukee, the only county in Wisconsin with a city of the first class based on population; Dane, Eau Claire, Marathon and Wood counties contain good-sized cities which serve as medical centers; and Iowa and Richland counties may be considered more rural in make-up. Each of these counties, except Richland, had over 50 per cent hospital deliveries. These 7 counties had 34.5 per cent of the total deliveries, but 66.4 per cent of the total cesarean sections during the period studied. The mortality rate was 2.11 per cent. Despite this low mortality, 52.2 per cent of all section deaths occurred in these counties. In Milwaukee County alone we find 27.6 per cent of all the state deliveries and 50.5 per cent of the sections which occurred in Wisconsin from 1934 to 1940, inclusive.

Correlations Between Counties Having a High Incidence of Section and a High Percentage of Maternal or Infant Deaths.—Lynch,[8] in discussing such a correlation, states, "This tremendously increased incidence of cesarean section should have done something to reduce the United States maternal mortality rate if the indications for the operation were sound and the mortality rate was properly low. The national maternal mortality rate, however, has remained practically unchanged for many years. Nor do graphs of maternal and fetal mortality by states and by their urban and rural communities show reductions which can be credited to this operation alone. The states with the lowest maternal mortality are not uniformly those which have the highest incidence of cesarean section, nor do the states with the highest incidence of cesarean section uniformly have the lowest mortality rate during the last 5 years. Yet we should expect such results if the operation now saved lives that would have been lost during other methods of delivery formerly employed and now largely abandoned."

In Wisconsin in spite of a decreasing maternal and infant mortality rate over the years studied, there is still no apparent correlation between areas having a high section incidence and the areas showing a low number of maternal or fetal deaths. In fact, counties showing a high section incidence are among those showing both high and low infant and maternal mortality rates.

General Information Concerning 1940 Sections

Unfortunately, prior to 1940 we have no data concerning Wisconsin cesarean sections other than the number and their location, except where death occurred. However, the new form of birth certificate gives information concerning the 1,439 sections done in

1940, which should be of value to the profession.

Prenatal Care.—The group of women who had sections had what would be considered adequate prenatal supervision, as only 1.5 per cent received no prenatal care. The majority, 68.7 per cent, started their prenatal examinations during the first trimester, 16.3 per cent during the second, 9.6 per cent during the third, and 3.9 per cent were without data.

Complications of Pregnancy and Labor.—As would be expected, this special group of pregnant women showed a high number of pregnancy and labor complications, 36.9 per cent having had some complication of pregnancy, as compared with 9 per cent of the total group delivered. Of the section patients, 54.4 per cent had some complication of labor, as compared with 17.4 per cent of all the pregnant women.

Parity.—As would be expected, a large number of the section patients were primigravida, 48.5 per cent, while 51.5 per cent were multiparous patients. Of these patients having had at least one previous pregnancy, nearly two-fifths were sectioned because of a previous cesarean section.

Prematurity.—Among the cesarean section patients we find 243 premature deliveries, or 16.9 per cent. Ante partum bleeding, toxemia, premature rupture of the membranes, undetermined causes and maternal diseases were the more common causes. However, in 70 cases no complications of pregnancy or labor were given. In these cases the reason for operation was often bizarre, hence the cause of prematurity was listed as operative interference. The total incidence of prematurity was high, despite the fact that this was a special group of patients that showed a large number of severe complications, as the state incidence of prematurity was between 5 and 6 per cent.

Type of Section.—As Table 3 shows, out of 1,439 sections done during 1940, we find that 86.4 per cent were of the classical type, 13.1 per cent were low cervicals, and only 7, or 0.5 per cent, were radical sections. The number of low cervical sections may have been slightly larger, because when the type of section was not stated, the section was considered of the classical type. The number of these was undoubtedly small, and would not materially change the distribution.

TABLE 3.—TYPE OF CESAREAN SECTION (Wisconsin 1940)

Type of Section	Wisconsin 1940		Massachusetts 1938 (De Normandie)	
	Number	Per Cent	Number	Per Cent
Classical	1,244	86.4	934	42.1
Low	188	13.1	1,206	54.4
Radical	7	0.5	39	1.8
Type not stated	--------	--------	37	1.7
Total	1,439	100.0	2,216	100.0

For comparison, let us consider what a similar survey showed in Massachusetts. In 1938, De Normandie[5] reported that 54.4 per cent of the 2,216 sections done were of the low cervical type, 42.1 per cent were classical, and 1.8 per cent were radical; in 1.7 per cent of cases the type was not stated.

Indications for Cesarean Sections.—These are shown in Table 4. Sections done because of a contracted pelvis or disproportion constituted 39.7 per cent. Previous section was the second most common indication, accounting for 14.9 per cent. Previous section was mentioned in 62 other cases; however, these were listed under the primary indication, most of which were done because of contracted pelvis. Together these totaled 276 previous sections, or nearly one-fifth of all the sections done for this reason. De Normandie,[5] in 1938, showed that previous section was the most common indication in Massachusetts, accounting for 28.6 per cent of all sections. Arnot,[2] reporting from the University of California and from his own private practice, found the incidence of previous sections to be 31.5 per cent.

In Wisconsin, if cesarean sections continue to increase, previous sections will no doubt become the most common indication. Other common indications were toxemias, placenta praevia, premature separation of the placenta, and uterine inertia. It was gratifying to see that only 2.4 per cent of

the sections were done because of eclampsia, but 35 eclamptics treated by cesarean section are still too many. In Massachusetts in 1938 with a larger total number of deliveries only 9 eclamptics were treated by cesarean section.

It should also be pointed out that 14 sections were done because of fetal asphyxia, prolapsed cord and fetal malformation, particularly hydrocephalus. Since the chance of obtaining a living child in these instances is poor, it is not sound obstetrical judgment to submit the patient to this rather hazardous operation if there is no other indication. The elderly primipara accounted for 31 sections; in many instances the patient was 31 or 32 years old and might take exception to being considered as "elderly." Many of the more bizarre indications were included in the miscellaneous group.

Summary

The tendency toward hospital deliveries in Wisconsin seems well established and its increase is assured, for both the physicians and the lay population have been educated to the fact that institutional delivery offers a real advantage over home delivery. However, we as physicians know that unless the hospital is adequately equipped, has trained personnel and staff organization and rules, hospital delivery has no real advantage over home delivery, and may even prove more dangerous.

In Wisconsin we have an adequate number of hospitals and except for a few areas they are well distributed. Hence our present hospital problem is to insure the continued improvement of now existing facilities, so that our Wisconsin hospitals offer parturient women a real advantage. Plass[12] after study-

TABLE 4.—INDICATIONS FOR CESAREAN SECTION
(Wisconsin 1940)

Indications	Wisconsin Sections For 1940		Indications	Massachusetts Sections for 1938 (De Normandie)	
	Number	Per Cent		Number	Per Cent
Contracted pelvis and disproportion	572	39.7	Previous section	635	28.6
Previous cesarean section	214	14.9	Contracted pelvis and disproportion	477	21.5
Toxemia	110	7.6	Placenta praevia	175	7.9
Placenta praevia	106	7.4	Separated placenta	104	4.7
Reason not stated	70	4.9	Toxemia	125	5.6
Premature separation of placenta	45	3.1	Eclampsia	9	0.4
Uterine inertia	40	2.8	Malposition of body	110	5.0
Eclampsia	35	2.4	Dystocia	202	9.1
Prolonged labor	33	2.3	Previous surgical operation	43	1.9
Elderly primipara	31	2.1	Associated medical conditions	61	2.8
Breech	28	1.9	Previous obstetric disaster	47	2.1
Other maternal complications	19	1.3	Elderly primipara	70	3.2
Occiput posterior	16	1.1	Obstructing tumors	18	0.8
Transverse presentation	14	1.0	Fetal distress	7	0.3
Previous pelvic surgery	13	0.9	Prolapsed cord	3	0.1
Elective procedure	13	0.9	Following operative attempts	7	0.3
Maternal congenital defects	12	0.8	By request or for sterilization	17	0.8
Contraction ring	12	0.8	Ruptured uterus	8	0.4
Miscellaneous	11	0.8	Injury or disease of pelvis	6	0.3
Other cephalic malpresentation	10	0.7	Bicornate uterus	3	0.1
Heart disease	9	0.6	Postmaturity	4	0.2
Ruptured uterus	8	0.6	Social and economic reasons	3	0.1
Fetal asphyxia	8	0.6	Varicosities of vagina	2	0.09
Diabetes	4	0.3	Congenital dislocation femur	1	0.05
Prolapsed cord	3	0.2	Malformation of fetus	1	0.05
Fetal malformation	3	0.2	Abdominal hernia	1	0.05
			Obesity	1	0.05
			Malformation of vagina	1	0.05
			Desire for live baby	1	0.05
			Frequent miscarriages	1	0.05
			Bizarre	25	1.10
			Not reported	48	2.20
Total	1,439	99.9		2,216	99.9

ing the increased number of hospital deliveries occurring in the United States concludes, "It may be offered that the trend toward institutional delivery is sound and its expansion inevitable, provided the hospitals continue to improve their equipment and personnel, and agree to such restrictions or individual initiative as are most conducive to the greatest safety for the mother and her child."

The Wisconsin record for cesarean sections when compared with other states is good. Our incidence, except in isolated areas, is no higher than, if as high as other states. Our section mortality is among the lowest reported. Despite this lower section mortality, cesarean section is increasing in importance as a cause of maternal deaths. If we hope to reduce further our maternal deaths and continue our improvement in obstetrical care, improvement in our cesarean section results will be an important factor. The medical profession and other educational groups should make a concerted effort to educate both physicians and patients alike that although cesarean section is often a lifesaving measure, it also is an extremely dangerous operative procedure unless the indications and contraindications are rigidly followed.

Conclusions

1. In 1934, 30.6 per cent of the total deliveries occurred in hospitals; by 1940 the percentage was 64.4.

2. There were 7 counties in the state with no hospitals; 3 of these counties had maternity homes.

3. An effort should be made to improve the now existing hospital facilities.

4. The incidence of cesarean section per total deliveries was 2.02 per cent for a seven-year period.

5. The incidence of cesarean section per hospital deliveries was 2.9 per cent for a three-year period.

6. The cesarean section mortality was 2.72 per cent during the seven-year period.

7. With the reduction in total maternal deaths, cesarean section is increasing in importance as a cause of maternal deaths.

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Comments on Treatment

Editor—A. J. QUICK, M. D., Marquette University, Milwaukee

Treatment of Cirrhosis of the Liver by Dietary Means

Hepatic cirrhosis still remains one of the important enigmas of medicine both in regard to cause and to treatment. New therapeutic approaches are therefore welcomed by the profession. The recent paper of Drs. A. J. Patek, Jr., and J. Post (Jour. Clin. Investigation 20:481, Sept. 1941) is particularly interesting since it presents an intensive study of fifty-four patients who were treated with a highly nutritious diet supplemented with vitamin B concentrates.

Their results obtained over a four-year period were compared with a control series of 386 cases from other New York hospitals not treated with this dietary method. Of the treated cases, twenty showed signs of clinical recovery gauged by gain in weight and strength to allow resumption of previous activities; by loss of ascites, edema, and jaundice; and by a return toward normal as measured by laboratory tests. In twelve, partial improvement or arrest of the disease process was noted, while the remaining twenty-two showed progressive failure. A greater longevity was observed in the treated cases than in the controls. At the end of six months, 72 per cent of the treated patients survived but only 57 per cent of the controls; after one year, 57 per cent of the treated and 39 per cent of the controls; and at the end of the second year 45 per cent of the treated still lived, whereas all but 21 per cent of the controls had died. The incidence of improvement as shown by these figures is in excess of any previously recorded.

Incidental to the development of their dietary treatment the authors made pertinent observations concerning the underlying cause of the hepatic cirrhosis. Their findings favor the hypothesis that while alcohol is the most common antecedent factor in the disease in the western hemisphere, it is not the direct cause; or stated specifically, "alcoholism per se does not cause cirrhosis." Close association between alcohol and the disease is not denied, although in 30 per cent of the cases with an unquestionable diagnosis of cirrhosis, no history of alcoholism was obtainable. Interestingly, four patients who had high-grade cirrhosis (evidenced by ascites, large liver and spleen and other characteristic signs and symptoms) and who after two years of intensive dietary treatment had recovered clinically were given 9 ounces of 40 per cent alcohol daily for periods ranging from six to eighteen months; yet in none did symptoms of cirrhosis redevelop.

In the Orient, the incidence of liver cirrhosis is high even though alcohol is not a factor as in our western hemisphere. There nutritional diseases such as beriberi and pellagra are endemic. This suggests a relationship between vitamin B deficiency and cirrhosis, which is further brought out by the striking fact that many of the cases in their series had signs of avitaminosis B, such as atrophy of the tongue, pellagrous dermatitis, polyneuritis, and dementia. These patients often had a history of malnutrition and weight loss,—in fact 81 per cent had eaten poor diets which were particularly low in meat and dairy products. Alcoholic patients often refused all food during their sprees.

The dietary regimen selected for the treatment of cirrhosis consisted in giving 3,000 to 3,600 calories daily divided as follows: proteins 115 to 140 Gm., fats 130 to 175 Gm. and carbohydrate 315 and 365 Gm. In addition the patient was given 50 Gm. of powdered brewer's yeast and 5 mg. of thiamin chloride daily and 5 cc. liver extract twice weekly by intramuscular injection. Two types of diet were employed, a semi-liquid and a solid. In the former, milk, cream, eggs and fruit juice supplied most of the calories but even in the solid diet, these articles of food were given in generous quantities.—ARTHUR J. PATEK, M. D.

Meat, A Body-Builder

By H. A. WAISMAN, Ph. D., R. W. BRAY, M. S., and IVA MORTIMER, M. S.
University of Wisconsin, Madison

Meat analysis, meat production, and meat in the family food supply are all represented in this author group. Mr. Waisman handles the field of meat analysis, Mr. Bray is an authority on meat production problems, and Mrs. Mortimer is well acquainted with all the home economics angles in the use of meat in the diet.

Mr. Waisman, a member of Sigma Xi and other national scientific groups, did both undergraduate and graduate work at the University of Wisconsin and is now a member of the biochemistry staff. He has worked extensively on the B-complex vitamins ever since science recognized that such vitamins could be isolated. His particular work has been the isolation and identification of B-complex vitamins, but in addition he has studied the quality of proteins, the effect of heat upon them, and the growth factors in chicks and rats. Mr. Waisman's present research is along a new line of biochemical research, a study of the relation of nutrition to bodily resistance, particularly in infantile paralysis. He has just completed publication, with C. A. Elvehjem, Ph. D., of a new textbook on meat, a summary of present nutritional knowledge of meat as a food.

The production, storage, and use of meat are the special interests of Mr. Bray. After completing his undergraduate work at the University of Wisconsin, he went to Kansas State Agricultural College for advanced study in meat animal production. Mr. Bray is a member of Alpha Zeta, national agricultural honorary fraternity, Phi Kappa Phi, national scholastic honorary fraternity, and the American Society of Animal Production. His research includes studies of the effect of freezing on tenderness of meat and experiments on storage temperatures in meat. He teaches practical courses in meat production, carcass values, selection of cuts of meat, and the choice and use of meat in the diet.

Mrs. Mortimer, whose work covers the use of meat in the family menu, holds four university degrees. She has a B.A. and an M.A., as well as her B.S. and M.S. degrees in home economics with foods as a major. She teaches home economics courses in elementary foods, problems in the family food supply, and nutrition and dietetics, and is a member of Sigma Delta Epsilon, science honorary sorority, and Omicron Nu, home economics honorary sorority.

—CHARLES A. DAWSON, M. D., River Falls.

AS RECENTLY as ten years ago, science was unable to prove that meat is a dietary necessity. As short a time ago as 1932 there was no evidence to deny that man could keep healthy on a plain vegetarian diet.

But things have happened swiftly in the last ten years. Nicotinic acid, which appears in quantity only in meat, has been revealed as the key to the cure for pellagra. Riboflavin, thiamin, and other B-complex vitamins have showed up richly in meat. Studies of protein have made it clear that meat is one of the few nutritionally complete protein foods.

All in all, the last decade has made the vegetarian diet as ridiculous as the whiskey cure for snake bite. Good health demands a balanced diet, and a diet isn't balanced if it doesn't supply meat.

Meat is Important For Many Reasons

Why is meat so important? Principally, as mentioned before, because it supplies the B-complex vitamins, those accessory food substances which can hardly be obtained in proper variety and amounts from other types of food. As for vitamin A, liver is a good source, though other meat products are much weaker in this respect. Meat is important as a source of protein, energy and minerals.

But it might be wise to study systematically the vitamins and other elements in meat.

In vitamins, first on the list is vitamin A. An average, reasonably active man needs 5,000 International Units of this vitamin. Four ounces of liver ordinarily supply about 7,000 units. Other types of meat contain far less of this vitamin, but samples of liver may even run as high as 20,000 I.U. to a quarter

(Continued on page 314)

MEATS » » POULTRY » » FISH

They Supply the Body With:

FUEL — Fats — Meat Fats and Lard

PROTECTIVE AND REGULATORY ELEMENTS

- Vitamins
  - A (Occurs in liver; protects the skin tissues against infections).
  - B-complex (These vitamins occur in abundance in all meats; essential to growth, digestion, and nervous stability).
    - Riboflavin
    - Thiamin
    - Nicotinic Acid
    - B_6 (Pyridoxine)
    - Pantothenic Acid
    - Biotin
    - Choline
  - K (Occurs in liver; protects against hemorrhages).
- Minerals
  - Calcium (Some in most meats; aids bones and teeth).
  - Phosphorus (Abundant in meats; important to growth).
  - Copper and Iron (Meat is a good source for the "blood" minerals).

BUILDING MATERIALS

- Minerals and Vitamins
- Proteins
  - All lean or mixed meats supply plenty of good, healthful, complete protein.
  - Adults need protein; children need it even more, for protein is the material of growth.

BEEF

PORK

LAMB

POULTRY

FISH

of a pound, so liver is an easily adequate source. Kidneys are of some importance here, too, for a quarter of a pound supplies 743 I.U. of the first vitamin.

Meats are inadequate in supplying vitamin D. Liver is the only meat form which contains vitamin D in any appreciable amount, and the vitamin content in this respect is variable and therefore not to be depended upon.

Vitamin C, the antiscorbutic vitamin, appears in meats in small amounts. It shows up in the adrenal glands and in some other tissues, though fruits and most vegetables are still the best practical sources.

In B-Complex Vitamins, Meat Leads

But in the B-complex vitamins, meat steps out in front.

Take thiamin for an example. Thiamin (vitamin B_1) is important for health of the nervous system, and has been publicized in recent months as the vitamin of whole grain foods. Four slices of whole wheat bread contain 160 I.U. of thiamin, but the same size helping of pork loin contains over 500 units. Heart meat is also high, with about 225 units in a quarter pound, and kidneys are equally good. Poultry and beef supply about 50 units in a quarter-pound helping, and so may help to supply the 600 I.U. which a healthy, moderately active man needs each day.

Nicotinic acid was mentioned earlier as the food element which cures pellagra. It appears in substantial amounts in all kinds of lean meats, but liver leads the parade. A 100 Gm. serving of beef liver contains 17.5 mg. of nicotinic acid.

Analyses of foods for the presence of nicotinic acid were originally carried on by experiments with dogs, for dogs must have the vitamin to prevent "blacktongue," an animal manifestation of the pellagra symptoms. Later chemical analysis was used, and still later microbiological tests were employed. Every study verified the conclusion that meat, supplying nicotinic acid as it does, is necessary to the prevention of pellagra.

Eat Liver For Vitamins

Riboflavin, which started out to be vitamin G, later was named vitamin B_2, and then ended up with its present chemical name, is a growth-promoting and nerve-stabilizing vitamin. Liver is one of the very best sources of that substance, and lean meats of all kinds do their part in supplying riboflavin. A quarter pound of liver contains up to 3,350 micrograms of riboflavin, where an adult needs only 2,700 micrograms.

Kidney follows along with 2,050 micrograms in 100 Gm. (less than a quarter pound), and heart is next with almost 900 micrograms. Even lamb, which trails with about 320, is still substantially a good source, and poultry, which offers only about 150, can even be used profitably for riboflavin needs in menu planning.

For vitamin B_6, beef liver, ham, and veal are all important sources. For pantothenic acid, liver, kidney, heart, beef round, and ham all rank high in content. Exact values for biotin, another B-complex vitamin, are not yet completed, but kidney and liver are excellent sources. Liver, kidney, and lean beef and pork all supply adequate amounts of choline, the final member of the B-complex, which is important to normal functioning of the liver and kidneys in the human body. Vitamin K, which helps promote blood clotting and prevents hemorrhages, is found abundantly in liver, though it does not appear to any considerable extent in any other meats. It was in liver, in fact, that the presence of vitamin K was first recognized.

Meat is important in many other respects, but in supplying the B-complex family of vitamins the necessity of serving meat in the daily diet makes itself apparent. These vitamins can hardly be obtained in sufficient quantities without meat.

Here Are Some Vitamin Tables

Here is a set of tables worked out at the University of Wisconsin measuring the presence in meat of vitamin A and the three chief B-complex vitamins, thiamin, nicotinic acid and riboflavin. These tables summarize the story of meat and vitamins:

Vitamin A logically comes first.

VITAMIN A

From this food (100 Gm.)*	man gets this much (International Units)	Each day he needs: (International Units)
Liver	5,000–20,000	5,000
Kidneys	700–750	"
Beef	about 60	"

* 1 pound equals 445 Gm.

As mentioned before, in the B-complex vitamins meat stands out. Here are the B-complex measurement tables, worked out at the University of Wisconsin.

THIAMIN (B_1)

From this food (100 Gm.)	man gets this much (micrograms)	Each day he needs: (micrograms)
Pork loin	1,540	1,800
Veal liver	520	"
Leg of lamb	300	"
Veal hindquarter	350	"
Whole wheat (best non-meat source)	510	"
Cabbage (next best non-meat source)	84	"

RIBOFLAVIN

From this food (100 Gm.)	man gets this much (micrograms)	Each day he needs: (micrograms)
Veal liver	3,300	2,700
Beef liver	3,000	"
Beef kidney	2,050	"
Beef heart	880	"
Leg of lamb	320	"
Pork loin	240	"
Veal hindquarter	290	"
Cheddar cheese (highest ranking non-meat food)	600	"
Whole wheat (next in rank)	216	"

NICOTINIC ACID

From this food (100 Gm.)	man gets this much (micrograms)	Each day he needs: (micrograms)
Beef liver	17,500	18,000
Beef kidney	10,000	"
Beef heart	7,000	"
Veal quarter	8,000	"
Pork ham	8,000	"
Beef round	7,500	"
Peanuts (best non-meat food source)	13,000	"
Whole wheat (next best)	5,000	"

That roughly outlines the vitamin content of meats.

Now for a look at proteins. How important are they? The 1939 issue of the *United States Department of Agriculture Yearbook* puts it this way, "If there were any one 'secret of life,' protein might be considered to be at the heart of it, since protein is the essential stuff of which all living tissue is made."

Meat is one of the most prolific sources of protein, and at the same time it is one of the best sources. Those two statements sound like a duplication. In actual fact, they are not.

Proteins are made up of a number of essential amino acids. Some proteins supply all these necessary acids, while others offer only a few. Thus a food can supply a great amount of protein, but unless that protein is made up of the right constituents, the food is not a superior protein source.

Meat fills both needs. It supplies protein abundantly, and it supplies the right form.

THE PLACE OF MEAT IN THE DIET

In 1940, the last year for which figures are available, the average American ate:

55.2 pounds of beef,
7.3 pounds of veal,
6.6 pounds of lamb,
87.2 pounds of pork and lard, and
21.6 pounds of poultry.

That totals up to an annual figure of 177.9 pounds of meat for each individual.

Nutritionists calculate that the meat consumption for good health should be at least 170 pounds of beef, veal, poultry, and lamb, and at least 60 pounds of pork and pork products. That's a total meat quota of 230 pounds for each person each year.

In 1940 Americans were 52 pounds below this good-health quota.

Liver Offers Plenty of Good Protein

Liver is the best protein source, and lean meats come next, followed by fowl and fish. General cuts of lamb and pork follow in line, then heart and kidneys, and then general cuts of beef.

All these are complete proteins. They are closely followed by other complete proteins: cottage cheese, eggs, milk and cheese. Peas and beans come into the picture as important sources of supplementary protein, but they do not supply all the essential amino acids which the body calls for.

Energy, measured in heat calories, is the next need of the body. Fat meat, of course, is one of the most productive sources of energy. But ordinary cuts of meat, too, supply relatively high energy requirements.

Here are the approximate caloric values offered by a four-ounce helping of each of the following normal foods:

Pork	300 calories
Lean beef	170 calories
Fish	135 calories

Such energy foods as butter, of course, far surpass ordinary meat cuts in caloric value. But for the backbone of the body's energy

supply, the staple part of the diet, meats are unequalled.

Minerals Come in Meats

Meats are not exceptionally rich in calcium, milk and cheese being the best sources of that mineral. However, fish in particular and meats in general, supply a small amount of available calcium for better teeth and stronger bones.

For phosphorus in the diet, meats, fish, and poultry are at the head of the list, and for iron and copper they are again exceptionally high.

In the light of these figures, no room remains for dispute about the food value of meat. Where science could neither confirm nor deny, science now can assert that meat is one of the best foods that can go on the family dinner table.

The Rules For Meat Cookery

There's no question, then, that meat is healthful. Now how about tastiness? Well, a thick, juicy, carefully cooked steak is one of the finest dishes ever planned, and the less expensive meat cuts can be just as tasty. What's more, they are as nutritious.

Two simple cooking rules insure good vitamin retention and good flavor in almost any kind of meat. The first: Cook all meats at low temperatures. If they are roasted, the temperature should be 300 to 350 F. If they are cooked on top of the stove, they should be simmered. The reason for the low temperature is that meats shrink and lose more of their juices under high heat. That destroys or drains off much of the thiamin, takes away a lot of the flavor, usuallys cooks the meat unevenly, and reduces the total number of servings a piece of meat will yield.

The second rule: Use dry heat only on tender cuts, and cook with moisture on the less tender pieces. Dry heat will not make meat more tender, though if you have a cut which needs no tenderizing it can be tastily prepared by broiling or roasting in an uncovered pan. But to make a cut of meat more tender, braise, stew, or simmer, either adding liquid or cooking in a closed dish to obtain moist heat.

In point of food value loss, roasting is the most costly cooking process. There is a 20 to 40 per cent loss in thiamin and a somewhat smaller loss of riboflavin in roasting except under low temperatures, and even here there is a minor loss of thiamin. Thiamin is the only B-complex vitamin in great danger of destruction by high heats. Riboflavin is more stable, and nicotinic acid goes almost unaffected by high temperatures.

Meat is an easily digested food, and a good food for people of almost any age. There is no evidence that any of the meats produce difficulty of digestion, because experiments show that pork, beef, poultry, fish, veal, and lamb are all from 86 to 90 per cent digested.

Health is No Luxury in Wisconsin

It is worth mentioning, in light of these facts, that Wisconsin people can well afford to be among the most healthy people in America. All the vital foods mentioned in previous articles in this nutrition series—butter, cheese, and vegetables—are produced in significant amounts in Wisconsin. With meat, the story is the same.

Last year the farmers of Wisconsin marketed almost 500,000 beef cattle—250,000 tons of beef-on-the-hoof.

Packers took 2,306,881 head of hogs from Wisconsin farms to produce tasty, energy-giving, and vitamin-supplying pork products.

Over 1,000,000 head of veal—1,129,979, to be exact—were marketed last year.

From Wisconsin farms 327,479 sheep and lambs were sent to the packer to be converted into lamb chops and roasts for the tables of the midwest.

For fried, broiled, stewed and roasted chicken, more than 7,000,000 fowls were purchased from Wisconsin producers in the last year.

Wisconsin, then, produces adequate supplies of meat as well as vegetables and dairy products.

All these foods are foods for health. All of them are easily available to the people of this state. All of them must do their share in the task of keeping Wisconsin strong, healthy, and productive in the difficult months to come.

The Nation at War

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Organization of Subcommittee Announced; Emergency Medical Service Program

SPEEDY progress in the development of the Emergency Medical Service program in Civilian Defense is assured through recent organization work undertaken by Dr. R. E. Fitzgerald, Milwaukee, state chief of Emergency Medical Service. Announcing the appointment of members of a special committee to assist in this program, Dr. Fitzgerald said, "The development of a sound and completely practical plan for medical participation in the Civilian Defense organization is fundamentally the concern of the medical profession. The physician has always contributed generously to the effort of the nation in its war problems, and must continue to do so, without at the same time being impractical in light of community needs. As state chief of Emergency Medical Service, I am satisfied that the program is well under way in Wisconsin."

Announcing the appointment of a special advisory committee composed of Dr. J. S. Supernaw, Madison; Dr. V. E. Ekblad, Superior; Dr. T. C. Hemmingsen, Racine; Dr. F. G. Anderson, Eau Claire; and Dr. A. G. Koehler, Oshkosh, Dr. Fitzgerald stated, "With the assistance of these physicians, each acting in an advisory capacity in areas embracing a number of counties, the Emergency Medical Service program will be developed along lines that assure that each county organization will be integrated to the state problem, and the state organization to the national problem."

Following its appointment, the special committee met in Milwaukee to hear a detailed presentation of the general subject of medical defense, and to correlate its own activities in the program. Addressing the conference were Dr. John S. Coulter, Chicago, regional medical officer, OCD, Sixth Corps area; Mr. W. L. Coffey, Milwaukee, director, Milwaukee County Institutions, and chief of Emergency Medical Service for Milwaukee County; Dr. Harry W. Sargeant, Milwaukee, superintendent of the Milwaukee County Hospital, and administrative assistant to Mr. Coffey, and Dr. J. S. Supernaw, Madison, chief of Emergency Medical Service for Dane County and a member of the special committee. Dr. Fitzgerald discussed the responsibility of the medical profession, and in commenting on this subject, Dr. Coulter said, "The detailed planning for Emergency Medical Service in Civilian Defense is vital to the protection of the welfare of our people in time of war. I am satisfied that the medical profession in Wisconsin is preparing fully to meet this need."

The first fully equipped first-aid post mobile unit to be completed in Wisconsin was displayed (see photograph, page 318). Planned and equipped by Dr. Supernaw and his assistant, Mr. R. O. McLean, Madison, the material and supplies are packed in a compact metal cabinet, specially made at the Vocational School in Madison. The unit is so designed that the top folds back to provide a wind shelter for the gasoline stove which is among the supplies provided. The cabinet contains the necessary medical and surgical supplies recommended by the Office of Civilian Defense, equipment for indicating the identity of patients and treatment given, and an inventory of supplies.

Occupational Deferments of Physicians, Dentists and Doctors of Veterinary Medicine*

THE following memorandum was released to all state directors of the Selective Service System on January 28:

Information previously distributed by this headquarters clearly indicates an overall shortage of physicians, dentists and doctors of veterinary medicine in the nation. Since war was declared, the shortage of these professional men has become acute. It is now manifest that every qualified doctor, dentist and veterinarian must serve where he can render the greatest professional service to the nation.

In order to accomplish this purpose, the President, by executive order, has formed the Procurement and Assignment Service, under the Office of Defense Health and Welfare Services. This service was formed primarily for the purpose of gathering and making available information with respect to the supply of qualified practitioners in the fields of medicine, dentistry and veterinary medicine, with a view of securing the most effective allocation of medical manpower as indicated by the requirements of the armed forces, civilian needs and industrial medicine.

To work with the headquarters of this service in Washington, there is being organized a committee for each corps area in the continental United States. Each committee will consist of five doctors, two dentists and one veterinarian. The committees have been accepted as advisers to the nine corps area surgeons, to the naval district surgeons and to the regional medical officers of the Office of Civilian Defense and will operate not only through the subdivisions of the medical, dental and veterinary associations but also with the profession at large in securing information and giving advice.

When considering the classification of any registrant who is a qualified physician, dentist or doctor of veterinary medicine, the director of Selective Service desires that local boards, through the state director, shall consult the procurement and assignment committee of the corps area for information as to the availability of qualified physicians, dentists and doctors of veterinary medicine in the community. This information shall be considered by the local board in determining the registrant's classification. The executive order referred to in no way affects the authority of the Selective Service System to classify registrants. The procedure has been established for the purpose of making such information available to local boards.

For the convenience of the state director and the local boards, the names and addresses of the chairmen of the nine corps area committees of the Procurement and Assignment Service are listed:

First Corps Area—Dr. W. G. Phippen, Salem, Mass.
Second Corps Area—Dr. A. W. Booth, Elmira, N. Y.
Third Corps Area—Dr. A. M. Shipley, Baltimore.
Fourth Corps Area—Dr. Edgar Greene, Atlanta, Ga.
Fifth Corps Area—Dr. E. L. Henderson, Louisville, Ky.
Sixth Corps Area—Dr. Charles H. Phifer, Chicago.
Seventh Corps Area—Dr. Roy W. Fouts, Omaha.
Eighth Corps Area—Dr. Sam E. Thompson, Kerrville, Texas.
Ninth Corps Area—Dr. Charles A. Dukes, Oakland, Calif.

LEWIS B. HERSHEY, *Director.*

* Reprinted from *The Journal of the American Medical Association,* February 7, 1942.

Fully Equipped First-Aid Box—Emergency Medical Service, Dane County.

SPECIALISTS*

The estimated number of specialists required per million men under the Protective Mobilization Plan, as prepared prior to the entrance of the United States into the war, was as follows:

Allergists	98
Anesthetists	270
Anesthetists (intratracheal)	27
Cardiologists	208
Dermatologists	98
Gastroenterologists	196
General operating surgeons	800
Assistants to operating surgeons	259
Internists	713
Laboratory specialists (clinical pathologists, bacteriologists, etc.)	651
Neurologists	196
Neuropsychiatrists	192
Neurosurgeons	134
Ophthalmologists	100
Orthopedic surgeons	459
Otorhinolaryngologists	281
Plastic and maxillofacial surgeons	136
Roentgenologists	348
Thoracic surgeons	125
Tuberculosis specialists	98
Urologists and syphilologists	293

* Reprinted from *Providence Medical News* (Rhode Island), March, 1942.

PHYSICIANS FOR PANAMA CANAL ZONE

The U. S. Civil Service Commission has announced an examination to secure physicians for important positions in the Canal Zone. Applications will be accepted by the Commission in Washington, D. C., until further notice.

Further information is given in the announcements which may be obtained, with application forms, at any first- or second-class post office, or from the U. S. Civil Service Commission, Washington, D. C.

ADDRESS, SIXTH CORPS AREA CHAIRMAN

Due to the fact that a large amount of mail in connection with Procurement and Assignment Service is arriving at the Federal Building, Chicago, announcement is made that the office of Dr. Charles H. Phifer, Sixth Corps Area Chairman, Procurement and Assignment Service, is located at 30 North Michigan Avenue, Chicago.

. . . . THE PRESIDENT'S PAGE . . . .

Rock Sleyster, M. D.

ON MARCH 7, 1942, the profession of our country was saddened by the loss of a great leader. In a narrower sense the physicians of Wisconsin, in the death of Rock Sleyster, lost a true friend. One cannot review the life of Rock Sleyster without unconsciously feeling pride in the knowledge that he was out of the soil of Wisconsin and for that reason one of us.

Born in Waupun, in his whole life he never strayed far from the region of his birth. It was fortunate indeed that his native state should, during a lifetime of activity, be the beneficiary of all the truly fine qualities that were his.

To illustrate, it is necessary to enumerate only a few of these qualities. Early in his medical career, while physician to the prison for the criminal insane at Waupun, Dr. Sleyster did clinical research in his chosen field of neuropsychiatry. Much of this work was published.

During World War I, he was a Major in the United States Army Medical Corps and enjoyed the rank of medical aide to the Governor of Wisconsin.

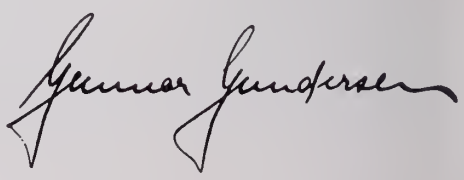
Dr. Sleyster held practically all the positions of trust in the gift of organized American medicine. His position of leadership emanated from his conviction that private initiative under a competitive system of medical practice could and did carry medical science and art further than any scheme of state medicine could hope to do. In forceful terms he called attention to the dangers of socialized medicine and warned frequently of the increasing seriousness of the mental disease problem in the United States. In his inaugural address, upon assuming the office of president of the American Medical Association, he cautioned that America might pay the price of a weakening individual responsibility for "what is called security."

A rare combination of qualities was necessary to accomplish in a short lifetime the achievements of Rock Sleyster. Many of these qualities pass rapidly in review. They were those of scientific interest, loyalty, culture, helpfulness, generosity, friendliness, devotion to principle, modesty, and gentleness.

The immortal Confucius said that "the aim of a gentleman is to see clearly, to understand what he hears, to be warm in manner, to be dignified in bearing, to be faithful in speech, to be painstaking in work, to ask when in doubt, to remember right when in sight of gain, to be easy to serve and hard to please, for nothing but what is right pleases him." Measured by all standards, Rock Sleyster was a thorough gentleman.

Wisconsin, and her physicians in particular, takes great pride in the only American Medical Association president to spring from its soil.

We shall not soon see his like again.



ROCK SLEYSTER, M. D.
Wauwatosa
(Editor's note.—Factual information appears on page 339)

THE WISCONSIN MEDICAL JOURNAL

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Annual Subscription ---------- Three Dollars-Fifty Cents Single Copies ---------- Fifty Cents

Advertising Representative: Cooperative Medical Advertising Bureau, 535 North Dearborn St., Chicago, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, Madison

Volume 41 APRIL, 1942 Number 4

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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« « « EDITORIAL » » »

Is It Council Accepted?

THE American Medical Association has maintained through the years three councils for the purpose of reviewing products to determine the accuracy of the manufacturers' claims. The Council on Pharmacy and Chemistry is the oldest of the councils, having been founded at the instigation of the late Dr. George Simmons in 1905. Its organization and method of procedure have been the pattern upon which the other councils have been formed and operated. The Council on Foods and Nutrition was an offshoot of the Committee on Medicinal Foods of the Council on Pharmacy and Chemistry. It was made an independent council in 1936. The Council on Physical Therapy was created in 1925 upon request initiated by the medical profession in Wisconsin through its regularly elected delegates to the American Medical Association.

Products or devices which have merit, which can pass the rigid tests established, can obtain the seal of acceptance of the councils. The manufacturer is required to demonstrate that his product will measure up to the claims made for it—demonstrate that the product when used as recommended has a useful place in the medical armamentarium and does not have a deleterious effect. Laboratory and clinical evidence must prove that the claims made by the manufacturer are accurate. No charge is made for council consideration.

These councils have a dual purpose; first, as a measure of protection for the physicians, and secondly, as a measure of protection for the public. Do you avail yourselves of this protection? Do you inquire of the detail man, "Is this council accepted?" Do you inquire of the equipment salesman, "Has this been accepted by the Council on Physical Therapy?"

The primary objective of the councils is to determine the efficacy of the product and to be certain that the advertising claims which are made for it are accurate. You can save yourself concern and worry if you prescribe those products which bear the seal of acceptance of the Council on Pharmacy and Chemistry. Likewise, the seal of the Council on Physical Therapy appearing on the therapeutic devices which are offered for sale is your assurance that they have been competently examined and tested.

Be "on the alert" when excuses or alibis are given for a product which does not bear the seal of approval.

New Cancer Film Strip Available

The Committee on Cancer, in collaboration with Dr. W. D. Stovall, state chairman for the American Society for the Control of Cancer, has prepared a new film strip designed for use by members of the Society in appearing before lay audiences to discuss the subject of cancer. The title is "Cancer in Wisconsin." It is comprised of sixty-one frames arranged in sequence similar to the Society's film strip "Health Achievements in Wisconsin." The Committee on Cancer has also prepared a manuscript to accompany the film strip as a basis for the physician's discussion.

A member of the Society may obtain the film strip, the manuscript, and the projector by advising the Society's office in Madison of the date on which he is scheduled to discuss cancer. The several speaking aids will then be forwarded to him in advance of his scheduled appearance so that he may familiarize himself with the contents of both the film strip and the manuscript. The accompanying reproduction of a portion of the film strip shows some of the illustrations used to bring to the people of Wisconsin a message on cancer in pictorial form.

Inasmuch as April is the month selected by the Women's Field Army for the conduct of an intensive educational campaign, it is anticipated that many requests will be made for the lanterns. Members are therefore urged to make their reservations for the film strip, the lantern, and the manuscript as soon as possible.

GENERAL PRACTITIONERS' SECTION

A General Practitioners' Section is being arranged for the 1942 meeting of the American Medical Association at Atlantic City in June. Such a sectional program for the general practitioner, which could be made comprehensive and practical, would tend to eliminate some of the time wasted in hurrying around from one section to another. Since there are many general practitioners in our State Society, the program should arouse special interest.

The Council was instructed at the last meeting of the House of Delegates to support this innovation. This is being done by publicizing the section through the councilors. In view of the war, attendance at the national meeting may be reduced. A suggestion has been made that to insure a good attendance from Wisconsin, the county societies defray part of the expense of sending one or more of their members to Atlantic City. This seems to be a good idea. Let us endeavor to give the General Practitioners' Section a fair trial.—R. L. MacCornack, M. D., 1941 delegate from Trempealeau–Jackson–Buffalo County Medical Society.

RESOLUTION

Whereas, The House of Delegates of the American Medical Association, in session at the 1941 Cleveland meeting, decided to create temporarily a General Practitioners' Section which would have equal standing with all other sections; and

Whereas, The permanency of this section will depend upon the attendance at, and interest in its sessions; and

Whereas, The Trempealeau–Jackson–Buffalo County Medical Society considers the establishment of such a section to be in the best interests of the American Medical Association and worthy of the support of the State Medical Society of Wisconsin; therefore, be it

Resolved, That the House of Delegates of the State Medical Society of Wisconsin hereby endorses the creation of such a General Practitioners' Section and instructs the Council to urge a large attendance of general practitioners from among our membership at its trial session at the next annual meeting of the American Medical Association.

Payment For Accident Cases

DO YOU know that through the efforts of the State Medical Society of Wisconsin means have been developed to assist you in the collection of professional fees due you for services rendered to those injured in automobile accidents? The Wisconsin Hospitals and Medical Payments Plan was developed several years ago to provide for the closer cooperation of insurance companies with hospitals and physicians in the payment of fees when liability insurance is involved.

The Wisconsin Hospitals and Medical Payments Plan grew out of a recognition that the large annual toll of persons injured or killed as a result of automobile accidents placed an increased financial burden both upon hospitals and upon physicians. The Society's committee which studied this question found that hospitals and physicians recovered only slightly more than half of fees for services given those involved in automobile accidents. Recognizing that the inability to collect, even for the initial outlay of materials, constituted a real financial strain which was becoming of such magnitude as to involve the welfare of the community served, as well as the people assisted, this joint agreement was made in an endeavor to insure remuneration to physicians and hospitals for services rendered to these patients.

The plan is approved by the insurance companies who are members of the American Mutual Alliance and the Association of Casualty and Surety Executives, as well as by the Wisconsin Hospital Association, the Catholic Hospital Association of Wisconsin and the State Medical Society of Wisconsin.

Members of the Society may obtain further information by addressing the secretary's office in Madison. A copy of the agreement follows:

Wisconsin Hospitals and Medical Payments Plan

Doctors and hospitals have in the past experienced difficulties in securing the payment of charges from patients who have collected damages from persons causing their injuries despite the fact that in such cases a part of the patient's financial recovery actually was based on hospital, medical, and surgical expense.

These principles are therefore enunciated in an effort to protect in so far as possible the interests of hospitals, medical and allied professions, insurance companies, the community and general public:

1. **Except as the patient or his lawful representative may otherwise direct, the fundamental confidential relationship between the physician or hospital and patient shall be maintained.** It is recognized that in order properly to submit a claim not only the early details of the injuries suffered must be disclosed, but also the expense which the injured party has incurred. In event of law suit or settlement, disclosure of this information is unavoidable, but the election so to disclose is that of the injured patient, and is his to be exercised. Therefore, when so authorized by the patient, the physician and hospital will supply to the interested insurance company or companies complete information concerning the injuries and prognosis.

2. The obligation incurred by the injured party for necessary medical, surgical and hospital care is one primarily owing to either the physician or hospital. Payments by the insurance company by way of indemnifying the patient therefor should be applied toward the liquidation of such obligation to the extent such funds are available, and to assist therein, the insurance companies will recognize orders on proper forms for reasonable charges upon such funds which ultimately may become payable to the patient or his personal representative. In so far as possible, the insurance company representatives will cooperate with the hospital and the physician in securing such orders. Where the payment is insufficient to afford satisfaction to all parties concerned, the insurance company will endeavor to pay physicians' and hospital bills on an equitable basis.

3. In order that the insurance companies may furnish the fullest cooperation (and for the hospital's or physician's own proper protection) the physician and hospital shall notify insurance companies promptly of any claim upon which an order has been or may be issued.

4. In event of settlement with a patient who refuses or has failed to sign an order, the insurance company will endeavor to carry out the principles set forth in paragraph two and when this cannot be done will notify the hospital and physician before settlement or if such advance notice is not possible, then as soon thereafter as can be done.

5. The company shall pay any expense incurred by the insured, in the event of bodily injury, for such immediate medical and surgical relief to others as shall be imperative at the time of accident.

6. A Conference Committee of eight, consisting of four insurance company representatives, and four representing the medical and hospital interests is created to mediate disputes and to further cooperation.

RECENT WISCONSIN LICENTIATES

The Wisconsin State Board of Medical Examiners, at a meeting held in the Hotel Loraine, Madison, on January 13, 14, and 15, licensed the following physicians in the practice of medicine after they had successfully passed an examination.

Name	*School of Graduation*	*Year*	*Present Address*
Baird, Katherine H.	Wisconsin	1938	721 North Seventeenth Street, Milwaukee, Wis.
Bandell, Herbert	Wisconsin	1940	Samaritan Hospital, Troy, N. Y.
Bartels, Wilbur W.	Loyola	1941	721 North Seventeenth Street, Milwaukee, Wis.
Bell, Joseph L.	Wisconsin	1940	Wisconsin General Hospital, Madison, Wis.
Bingham, Margaret N.	Oregon	1940	Wisconsin General Hospital, Madison, Wis.
Bryce, James W.	Marquette	1940	Saginaw General Hospital, Saginaw, Mich.
Connors, Angie	Woman's Medical College, Philadelphia	1937	Marshfield, Wis.
Crenshaw, John C., Jr.	Pennsylvania	1938	721 North Seventeenth Street, Milwaukee, Wis.
Denholm, Nan A.	Illinois	1940	Madison General Hospital, Madison, Wis.
Dickson, Franklin H., Jr.	Illinois	1941	Eagle River, Wis.
Donoghue, F. Edward	Columbia	1940	1871 North Sixty-Eighth Street, Milwaukee, Wis.
Erickson, Theodore C.	Minnesota	1931	Wisconsin General Hospital, Madison, Wis.
Gaenslen, Frederick G.	Wisconsin	1940	425 East Wisconsin Avenue, Milwaukee, Wis.
Galgano, Rosco S.	Marquette	1941	St. Michael's Hospital, Milwaukee, Wis.
Golden, Peter B.	Wisconsin	1940	Cook County Hospital, Chicago, Ill.
Guenther, Vernon G.	Northwestern	1940	Campbellsport, Wis.
Haseltine, Charles P.	Harvard	1940	537 Watson Street, Ripon, Wis.
Henry, Earl W.	Johns Hopkins	1940	Hawthorne, Wis.
Jones, William E.	Oregon	1940	Wisconsin General Hospital, Madison, Wis.
Lobb, Lois	Minnesota	1936	Eau Claire, Wis.
Low, Niels L.	South Carolina	1940	721 North Seventeenth Street, Milwaukee, Wis.
Meyer, Bertrand W.	Chicago	1939	Wisconsin General Hospital, Madison, Wis.
Meyer, Ralph R.	Harvard	1940	Wisconsin General Hospital, Madison, Wis.
Mings, Dwain E.	Indiana	1940	Wisconsin General Hospital, Madison, Wis.
Wesche, Henry C.	Northwestern	1925	Washburn, Wis.
Zahl, Wesley H.	Northwestern	1940	Whitewater, Wis.

The following physicians were granted licenses through reciprocity:

Name	*School of Graduation*	*Previous Address*	*Present Address*
Beck, John G.	Northwestern	Illinois	Sturgeon Bay, Wis.
Burger, Joseph M.	Northwestern	Illinois	Hollister, Wis.
Cameron, Norman	Johns Hopkins	Maryland	Bascom Hall, Madison, Wis.
Henderson, Norman C.	Arkansas	Arkansas	Fond du Lac, Wis.
Holloway, Opie R.	Arkansas	Arkansas	Box A, Wauwatosa, Wis.
Horowitz, William	Wisconsin	New York	St. Mary's Hospital, Madison, Wis.
Kincaid, Charles K.	Ohio State	Ohio	Court House Annex, Eau Claire, Wis.
Klotz, Arthur P.	Chicago	New York	Gillett, Wis.
Qualls, Charles L.	Loyola	Missouri	Juneau, Wis.
Schacht, Walter J.	Northwestern	Michigan	7845 Harwood Avenue, Wauwatosa, Wis.
Schweiger, Lamont R.	Rush	Minnesota	425 East Wisconsin Avenue, Milwaukee, Wis.
Uhley, Milton H.	Northwestern	Illinois	536 West Wisconsin Avenue, Milwaukee, Wis.

AMENDMENT TO CONSTITUTION

In conformity with the provision in the Constitution of the State Medical Society that amendments shall be published twice before the meeting on which they will receive a vote, the following amendment, presented at the request of the Council, is printed:

Resolved, That the Constitution of the State Medical Society of Wisconsin be amended by striking from Article II the eleventh and twelfth lines.

Annual Spring Clinics

Chippewa Falls, April 27—Wausau,

Surgery—Medicine—Industrial Surgery—Obstetrics

GENERAL CHAIRMAN

S. E. GAVIN, M. D.
Fond du Lac

Dr. Gavin is serving as the Wisconsin committeeman for the Sixth Corps Area. Committee on Procurement and Assignment Service

TOPICS:
4:05 p. m. The Medical Profession and the War

ROUND-TABLE DINNER:
6:15 p. m. Industrial Surgery

MEDICINE

W. L. PALMER, M. D.
Chicago, Illinois

Associate professor of medicine, University of Chicago School of Medicine, Chicago

TOPICS:
10:10 a. m. Functional Colitis
2:20 p. m. Peptic Ulcer—Medical Management

ROUND-TABLE DINNER:
6:15 p. m. Gastro-intestinal Diseases

MEDICINE

W. S. MIDDLETON, M. D.
Madison

Dean and professor of medicine, University of Wisconsin Medical School, Madison

TOPICS:
10:50 a. m. Carcinoma of the Lung
4:35 p. m. Shock 1917–1942

ROUND-TABLE DINNER:
6:15 p. m. Newer Drugs

OBSTETRICS AND GYNECOLOGY

H. H. CUMMINGS, M. D.
Ann Arbor, Michigan

TOPICS:
9:45 a. m. Postpartum Care; Repair of Lacerations and Episiotomy Wounds
3:20 p. m. Complications of Menopause

ROUND-TABLE DINNER:
6:15 p. m. Obstetrics and Gynecology

REGISTRATION

Each member is urged to return the registration blank included in the special bulletin sent to members of the Society. The Spring Clinic in each city will be held under one roof.

CHIPPEWA FALLS—HOTEL NORTHERN
WAUSAU—HOTEL WAUSAU
FOND DU LAC—HOTEL RETLAW

A registration fee of $5 is charged for the full day's postgraduate program. This sum covers registration and a round-table dinne

April 28—Fond du Lac, April 29

...cs and Gynecology—The Physician and the War

GENERAL SURGERY

F. A. STRATTON, M. D.
Milwaukee

Clinical professor of surgery, Marquette University School of Medicine, Milwaukee

TOPICS:
11:15 a. m. Postoperative Emergencies
2:50 p. m. Peptic Ulcer—Surgical Management

ROUND-TABLE DINNER:
6:15 p. m. General Surgery

INDUSTRIAL SURGERY

IRWIN SCHULZ, M. D.
Milwaukee

TOPICS:
11:40 a. m. Injuries of the Hand
5:05 p. m. Intra-abdominal Injuries

ROUND-TABLE DINNER:
6:15 p. m. Industrial Surgery

ANATOMY

WALTER ZEIT, PH. D.
Milwaukee

Assistant professor of anatomy, Marquette University School of Medicine, Milwaukee

TOPICS:
9:30 a. m. Anatomy of the Female Pelvis
2:00 p. m. Anatomy of Stomach and Gallbladder

ROUND-TABLE DINNER:
6:15 p. m. General Surgery

OBSTETRICAL MANIKIN DEMONSTRATIONS

W. C. KEETTEL, M. D.
Madison

Special instructor, Bureau of Maternal and Child Health, State Board of Health, Madison

Throughout the morning and afternoon sessions Dr. Keettel will be available for individual obstetrical and gynecological conferences with physicians attending the Spring Clinics. Dr. Keettel will also participate in the round-table discussion on obstetrics and gynecology in the evening.

ROUND-TABLE DINNERS

Members of the Society have urged that more time be devoted to the round-table dinners. In compliance with this popular request the Council on Scientific Work has dispensed with the usual evening program and has made the entire evening available for the round tables. They will be conducted from 6:15 to 9:00 p. m.

NEWER DRUGS	W. S. Middleton
OBSTETRICS AND GYNECOLOGY	H. H. Cummings and W. C. Keettel
GENERAL SURGERY	F. A. Stratton and Walter Zeit, Ph. D.
INDUSTRIAL SURGERY	Irwin Schulz and S. E. Gavin
GASTRO-INTESTINAL DISEASES	W. L. Palmer

1942 SPRING CLINIC PROGRAM

Monday, April 27—Chippewa Falls, Hotel Northern
Tuesday, April 28—Wausau, Hotel Wausau
Wednesday, April 29—Fond du Lac, Hotel Retlaw

S. E. Gavin
General Chairman

MORNING SESSION

9:00 a. m.–12:15 p. m.

9:00 Registration

9:30 Anatomy of the Female Pelvis
Walter Zeit, Ph. D., assistant professor of anatomy, Marquette University School of Medicine, Milwaukee

9:45 Postpartum Care; Repair of Lacerations and Episiotomy Wounds
H. H. Cummings, Ann Arbor, Michigan

10:10 Functional Colitis
W. L. Palmer, associate professor of medicine, University of Chicago School of Medicine, Chicago

10:35 RECESS
Obstetrical Manikin Demonstration
W. C. Keettel, Bureau of Maternal and Child Health, State Board of Health, Madison

10:50 Carcinoma of the Lung
W. S. Middleton, dean and professor of medicine, University of Wisconsin Medical School, Madison

11:15 Postoperative Emergencies
F. A. Stratton, clinical professor of surgery, Marquette University School of Medicine, Milwaukee

11:40 Injuries of the Hand
Irwin Schulz, Milwaukee

AFTERNOON SESSION

2:00–5:30 p. m.

2:00 Anatomy of Stomach and Gallbladder
Walter Zeit, Ph. D.

2:20 Peptic Ulcer—Medical Management
W. L. Palmer

2:50 Peptic Ulcer—Surgical Management
F. A. Stratton

3:20 Complications of Menopause
H. H. Cummings

3:50 RECESS
Obstetrical Manikin Demonstration
W. C. Keettel

4:05 The Medical Profession and the War
S. E. Gavin, Fond du Lac, committee member, Sixth Corps Area, Office of Procurement and Assignment Service

4:35 Shock 1917–1942
W. S. Middleton

5:05 Intra-abdominal Injuries
Irwin Schulz

ROUND-TABLE DINNERS

6:15–9:00 p. m.

6:15 Round-Table Dinners

Newer Drugs — W. S. Middleton, Madison

Obstetrics and Gynecology—H. H. Cummings, Ann Arbor, Michigan; and W. C. Keettel, Madison

General Surgery—F. A. Stratton, Milwaukee; and Walter Zeit, Ph. D., Milwaukee

Industrial Surgery—Irwin Schulz, Milwaukee; and S. E. Gavin, Fond du Lac

Gastro-intestinal Diseases—W. L. Palmer, Chicago, Illinois

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

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Mrs. H. Kent Tenney, Madison

How Can the Legislative Committee of the Woman's Auxiliary to the State Medical Society of Wisconsin Be Most Useful?

By MRS. H. KENT TENNEY

Madison

THE answer always is "be informed,"—keep up with medical legislation, be ready and able to discuss these matters formally or informally. You may read the national health bills in *The Journal of the American Medical Association,* and if you are in Madison when the legislature is in session, you may hear various state health measures discussed in the committee hearing rooms and in the Assembly and Senate chambers. Although we may be only onlookers, it is interesting and important to be informed on those bills which the State Medical Society either endorses or opposes on the basis of what will advance the public health. We may then discuss the bills at home with our husbands and thus help them keep informed on these affairs, which in their busy lives they might otherwise miss.

We can also interpret these matters to our neighbors, friends, and the general public. This, I believe, is our most useful field. We, as physicians' wives, know too well how much a physician gives to his patients and his community,—his long hours, interrupted meals, and disturbed nights. However, most thinking people understand this and respect the physician for his unselfishness.

The important thing which the public may not always understand is that one of the aims of the county, state, and national medical societies is to protect and improve the public health. This aim is simple and yet sometimes may not be appreciated by the average lay person. Often the supposedly well-informed woman will mistakenly misquote some current item concerning an untried cure for a disease. Some will spend time and money on health cures that have no sound medical background and because of only a fancied ailment, and cannot believe that they are being cheated. These are the women who must be told again and again the aim of the medical societies,—to protect the laity against misinformation and against a lower standard of medical service, which would have resulted had health insurance bills in past sessions of the legislature been enacted. These well-meaning but partially informed persons so often fail to appreciate what has been done in providing free and low-priced quality medical care and fail to realize that the standard of medical care must be lowered to fit any of the present proposals.

I believe it is the duty of the members of the Auxiliary to take up this challenge, to provide the public enlightenment in discussions on health insurance, state medicine, or other proposals inimical to the public health.

Don't be afraid to join the discussion and, above all, don't antagonize or give the impression that you are hurt or insulted by questions. Keep yourself informed and, if necessary, get some physician or a representative from the State Medical Society to tell these groups what has been and is being done. Physicians should take time to study these questions and inform the public, so that the administration of medical care will, in the future as in the past, be such that Wisconsin will continue to make tremendous advances in public health. Even in this time of national crisis these questions will come up, and we must do what we can to help settle them for the good of all.

Organization*

By MRS. JOHN L. BAUER

Chairman of Organization, Woman's Auxiliary, American Medical Association

TODAY, the first item of business on America's agenda is war—defensive and offensive—all out war. War demands the greatest efficiency. The health and strength of the nation are of vital importance, and the doctor stands ready to do his part.

The Congress has passed an amendment to the Selective Service Act, which calls for registration of every man up to the age of sixty-five, and which places all men under forty-five subject to service at the order of the Selective Service Boards. In *The Journal of the American Medical Association,* dated December 27, 1941, is an enrollment form for Procurement and Assignment Service for physicians. It is estimated that the raising of the selective service age from twenty-eight to forty-five will make available for service 60,000 physicians.

We can no longer say *times are critical;* they are now *tense.* Never in the history of the Woman's Auxiliary to the American Medical Association have its members been called upon for greater service than at present.

Women have been likened to anchors, stabilizers and to other synonyms of steadiness. The wives of doctors have many times shown their ability to stand by steadily in times of stress and strain. Now, as never before, are these women called upon to the greatest service of their lives. By the very nature of their training and environment they are prepared to be leaders in the communities, to be the pillars of strength in emergencies, and to be the comforters in times of disaster and misfortune.

This is the propitious time to organize new county auxiliaries, new state auxiliaries and to strengthen and increase those auxiliaries already organized. This is the time for unity. What greater service can you, a doctor's wife, do than to band closely together with the other auxiliary members and give of your time and strength to make life easier and pleasanter for those women who have husbands or sons (or both) in the service of the United States of America? These women will need your encouragement, and you can help them and, incidentally, each other.

In the fall issue of the *Bulletin* I listed some of the functions of an Auxiliary. They are still important, but I would add this one:

> To make a record of doctors in service in each county in order to make frequent personal contacts with their families, to ascertain their needs and to assure their comforts. This is a humane function and may be enlarged to include personal attention to families of patients.

Perhaps those states, which in times of prosperity and peace did not choose to organize auxiliaries, may in this war period feel a rising need for the help of organized women. We have told them in the past that we needed them, and we are hopeful that the medical societies in Massachusetts, Connecticut, Rhode Island, Vermont, Maine, Maryland, North Dakota, Nevada, New Mexico and Wyoming will now be drawn toward us in a spirit of unity and helpfulness. We assure them a hearty welcome. In union there is strength. Let us pledge our loyalty to our country.

* Reprinted from *Bulletin of the Woman's Auxiliary to the American Medical Association,* Spring 1942.

County Auxiliary Proceedings

Dane

The Woman's Auxiliary to the Dane County Medical Society had a luncheon meeting on March 9 at the home of Mrs. Arthur G. Sullivan. Twenty-six members and two guests were present.

Mrs. Stuart A. McCormick introduced Mr. George B. Larson, assistant secretary of the State Medical Society, who gave an illustrated lecture entitled "Health Achievements in Wisconsin." The film by this title was prepared by the Committee of Health and Public Instruction of the State Medical Society.

Mrs. William A. Werrell suggested that the Auxiliary form two canteens as there are too many for one unit.

Mrs. C. G. Reznichek has been appointed chairman of the cancer campaign. In her report of activities in this field, she called attention to the fact that April is cancer control month. The members were asked to introduce the cancer campaign to other groups to which they belong.

Dodge

Miss Dorothy Christopherson, an instructor of home economics on the staff of the vocational and adult education plan in Beaver Dam, was the speaker at the dinner meeting of the Woman's Auxiliary to the Dodge County Medical Society at the Rogers Hotel, Beaver Dam, on February 26. Miss Christopherson, who is teaching classes in nutrition to aid in the Red Cross defense program, emphasized the importance of nutrition.

Fond du Lac

A dinner at Groll's Coffee Shoppe preceded the meeting of the Woman's Auxiliary to the Fond du Lac County Medical Society on February 26. Seventeen members were in attendance.

Mrs. J. P. Connell, Fond du Lac, reported on the meeting of the State Board of Directors held in Milwaukee on February 4. Mrs. Connell and Mrs. S. E. Gavin were delegates to the meeting.

Red Cross activities were discussed. The Auxiliary has arranged a schedule so that one or more members are at Red Cross headquarters every day to assist where needed. A meeting for Red Cross work was held at the home of Mrs. F. M. McGauley, Fond du Lac, on March 26.

Miss Ruth Reber of the Wayland Academy faculty at Beaver Dam read Lillian Hellman's play, "Watch on the Rhine."

Kenosha

Two movie films, "Bomber" and "The T. V. A. Power and Production Plant," were presented by Mr. Walter Lourigan of the Kenosha Historical and Art Museum to the Woman's Auxiliary to the Kenosha County Medical Society at the March 3 meeting at the home of Mrs. Leif H. Lokvam, Kenosha. Twenty members were in attendance.

Mr. Judson Stapelkamp also talked to the group, urging them to do their part in helping the Civilian Defense effort in Kenosha. A donation of $25 to the Civilian Defense Council was voted.

Mrs. Edgar F. Andre, Kenosha, was appointed chairman of the newly formed committee to finance the sending of Girl Scouts to camp this summer. A report was also made on the ticket sale of "How Green Was My Valley."

Luncheon was served following the meeting.

Milwaukee

The Woman's Auxiliary to the Medical Society of Milwaukee County held a luncheon meeting at the Knickerbocker Hotel on March 13. Ninety-seven members were in attendance, as well as twenty-two members of the Minstrel Chorus of the Medical Society who were guests and entertained with several selections.

Dr. R. E. Fitzgerald, state chairman of Procurement and Assignment Service, addressed the group on the subject of this service.

At the business meeting it was reported that $247.50 was the amount of proceeds on the card party given for the Red Cross. The chairman of the Philanthropic Committee presented a recommendation to use $150 assigned for philanthropic purposes as needed for special training for those members who were formerly nurses and for others qualified to become instructors in classes for nurses and home nursing. This work will be done in cooperation with Red Cross and V. N. A. The recommendation was carried unanimously.

Dr. Tibor Payzs, a native of Budapest, Hungary, and now on the faculty of Loyola University, Chicago, gave a talk on "Our War Aims and Our Peace Aims." This was followed by discussion.

Co-chairmen of the meeting were Mmes. E. F. Barta and W. F. Grotjan. Hostesses included Mmes. B. P. Churchill, L. J. Van Hecke, and C. C. Schneider.

Racine

Mrs. R. D. Jamieson, Racine, entertained twenty members of the Woman's Auxiliary to the Racine County Medical Society at a buffet supper on February 26. Miniature flags were used as centerpieces at the small tables, while red candles illuminated a single rose in a pear-shaped bowl on the dining room table. The evening was spent in knitting, sewing, and playing cards.

Mrs. I. F. Thompson, Racine, reviewed an article entitled "How Well Do You Know Your First Aid?" before members of the Racine Auxiliary on March 9 at the home of Mrs. J. F. Henken, Racine. The article, which was from *Hygeia*, was presented in the form of a quiz.

Supplementing her talk, "Nutrition and Meal Planning as Taught at Park High," Miss Louise Thompson, guest speaker, displayed colorful posters made by her students. Miss Thompson, who is home economics instructor at the high school, is the daughter of Dr. I. F. Thompson, health commissioner.

During the meeting members engaged in Red Cross work. Tea was served later at a table brightened with pink sweet peas entwined in candelabra. Mrs. L. O. Mastalir, Burlington, and Mrs. F. C. Christensen, Racine, poured. Assisting hostesses included Mmes. H. G. Walters, E. C. Pfeifer, Thompson, G. L. Rothenmaier, and H. C. Miller. Mrs. E. Oestrick, New London, and Mrs. Robert Hamilton, Racine, were guests.

Rock

Early cancer is curable, and with this knowledge the Women's Field Army of Wisconsin is fighting the disease which ranks second in Wisconsin as a cause of death. At the monthly meeting of the Woman's Auxiliary to the Rock County Medical Society on February 24, initial plans for organization were made. Mrs. G. E. Stoddart, Beaver Dam, state commander of the Woman's Field Army, outlined the objectives of the organization which was begun in Wisconsin in 1936. In making a plea for continued vigorous fighting in disseminating information, she said that sixty or seventy times as many deaths will occur from cancer this year as there were casualties at Pearl Harbor.

Mrs. H. E. Kasten, Beloit, and Dr. Margaret Hatfield, Janesville, are Rock County captains. Mrs. Lloyd Ballard, adjutant, who has been carrying on the work on Beloit College campus, and Mrs. F. E. Brinckerhoff, Beloit, program chairman of the Beloit unit, attended the meeting.

Dinner was served to twenty-five preceding Mrs. Stoddart's talk. Mrs. W. T. Clark, Janesville, introduced the speaker.

Sauk

Mrs. T. W. Walsh, Sauk City, reports that the Woman's Auxiliary to the Sauk County Medical Society, held a luncheon meeting in the Silver Room of the Warren Hotel, Baraboo, on February 24. Thirteen members were in attendance. Mrs. J. S. Supernaw, state president, and Mrs. O. W. Friske, state organization chairman, were guests.

After a most inspirational talk by Mrs. Supernaw, the group held an informal discussion regarding the possibilities for activities in the Auxiliary. A motion was carried to place one subscription for the *Bulletin*. For the remainder of the year meetings will be held in the homes of Baraboo members with members from other communities acting as assisting hostesses.

In an effort to build up the treasury, each member will pay 25 cents at every meeting attended. The hostesses will furnish the refreshments and will plan the program which may consist of a musical program, book review, Red Cross work, bridge, or anything else they desire.

Sheboygan

Twenty-one members were present at the meeting of the Woman's Auxiliary to the Sheboygan County Medical Society at the home of Mrs. Paul B. Mason, Sheboygan, on March 11. Mrs. J. W. McRoberts was the assisting hostess.

Attorney Erwin N. Pauly of Sheboygan Falls was the guest speaker, his subject being relationships between the United States and South America.

Mrs. Horace J. Hansen of Sheboygan Falls, president, introduced the speaker and presided at the business meeting. Following the meeting refreshments were served, with Mrs. Hansen pouring.

Walworth

The Woman's Auxiliary to the Walworth County Medical Society met at the Traver Hotel, Lake Geneva, for a one o'clock luncheon on March 10. The Lake Geneva members were hostesses.

The treasurer's report showed a balance of $428.

Due to the tire shortage, the question of discontinuing afternoon meetings was discussed. It was decided to cancel the April meeting and hold the next one at Green Shutters, Whitewater, on May 11. A one o'clock luncheon will be served at that time, and this will conclude the meetings until fall.

The business meeting was followed by a social hour, contract bridge being played.

Washington—Ozaukee

The Washington–Ozaukee County Medical Auxiliary had a luncheon meeting at the Beacon Restaurant, West Bend, on March 12, fourteen members being present. A program followed at the home of Mrs. A. H. Heidner, with Dr. Heidner as the principal speaker. Dr. Heidner, one of the two chiefs of Emergency Medical Service in Washington County, discussed "Medical Defense."

Mrs. R. L. Fisher, Allenton, reported on the contents of the Auxiliary section of the last four *Wisconsin Medical Journals*. Mrs. A. H. Barr, Port Washington, discussed political party organization in its relation to legislation.

A report of the midyear meeting of the State Booard of Directors was given by the president, Mrs. Maurice E. Monroe, Hartford, who attended the meeting.

Waukesha

The Woman's Auxiliary to the Waukesha County Medical Society was entertained at the home of Mrs. F. M. Scheele, Waukesha, on March 4, with Mmes. C. C. Edmondson and Henry A. Peters and Miss Hertha Voje as assisting hostesses. Following the meeting a delicious dinner was served. Seventeen members and one guest, Mrs. W. C. Edmondson of Waukesha, were present.

A balance of $27.70 was reported in the treasury. The treasurer quoted an announcement regarding dues from the spring number of the *Bulletin.*

The resignations of Mmes. U. J. Tibbitts, W. D. James, and P. L. Eisele were accepted with regret. Mrs. Tibbitts, a charter member of the Auxiliary, is in poor health and unable to attend meetings. Mmes. James and Eisele are with their husbands who are in the armed forces.

Plans for a public relations meeting to be held April 30 were discussed. Dr. W. W. Bauer, director of the Bureau of Health Education of the American Medical Association, will be the speaker.

Mrs. T. H. Nammacher, president, reported on the meeting of the State Board of Directors, in Milwaukee on February 4.

A group of women from Waukesha presented a timely play, "A Woman's Privilege." The play dealt with the benefits of community service and was directed by Mrs. H. J. Laatsch of Waukesha.

ATTENTION, AUXILIARY MEMBERS

A few more months, and the members of the Woman's Auxiliary to the American Medical Association will be arriving in Atlantic City, New Jersey, for their annual convention, June 8–12.

Have you made your reservations? If not, send your request *at once* to Haddon Hall, Atlantic City, New Jersey.

Society Proceedings

Brown—Kewaunee—Door

Dr. Harry R. Foerster, assistant professor of dermatology at the University of Wisconsin Medical School, and assistant clinical professor of dermatology at Marquette University School of Medicine, was the guest speaker at the monthly meeting of the Brown–Kewaunee–Door County Medical Society in Green Bay on March 12. The illustrated lecture by Dr. Foerster was entitled "Eczema and the Allergic Skin Diseases."

The meeting was preceded by a 6:30 dinner at the Beaumont Hotel. At a business session reports were made by the Defense Committee, the Board of Censors, and the Advisory Committee on their agreement with the Social Security Committee of the County Board of Supervisors.

Fifty members were in attendance.

Chippewa

The regular monthly meeting of the Chippewa County Medical Society was held at Hotel Northern, Chippewa Falls, on March 10, with a 6:30 dinner preceding the meeting. The guest speakers were Dr. Arthur M. Olson, instructor in medicine, and Dr. Kinsey M. Simonton, instructor in otolaryngology, both of the Mayo Foundation, Rochester.

Clark

Dr. Lenore Patrick of the State Board of Health addressed members of the Clark County Medical Society at the Woodland Hotel, Owen, on March 19. Her talk on "Maternal and Child Welfare" was illustrated with moving pictures.

Dane

Members of the Dane County Medical Society held their regular monthly meeting at the Madison Club on March 10, with Dr. Alfred W. Adson, professor of neurosurgery at the Mayo Foundation, as their guest speaker. The title of his address, which was illustrated, was "The Diagnosis and Surgical Treatment of Essential Hypertension." Discussion of Dr. Adson's address was opened by Dr. Theodore C. Erickson, associate professor of surgery at the University of Wisconsin Medical School.

This meeting was well attended, with seventy-five members present.

A meeting of the Board of Trustees at the Madison Club preceded the meeting.

Dodge

Following a dinner at the Hotel Rogers in Beaver Dam, on February 26, at which members of the Dodge County Medical Society were guests of Dr. George H. C. Hoyer, the regular monthly meeting of the Society was held, with Dr. Arthur G. Sullivan, Madison, as their guest speaker. He spoke on "Medicolegal Pitfalls."

The meeting was well attended.

Douglas

Twenty-five members of the Douglas County Medical Society were present at a meeting at Hotel Superior, Superior, on March 4. Dr. John E. Gonce, professor of pediatrics at the University of Wisconsin Medical School, spoke to the group on "Urinary Tract Infections in Children."

Eau Claire—Dunn—Pepin

Two doctors from the Mayo Foundation, Rochester, were guest speakers at the monthly meeting of the Eau Claire–Dunn–Pepin County Medical Society on February 23 at Hotel Eau Claire. Dr. Walter F. Kvale, instructor in medicine, presented a paper entitled "Clinical Use of Substances Which Impair Coagulation of the Blood," and Dr. W. W. Heyerdale lectured on "Modern Management of Varicosities of the Lower Extremities."

Fond du Lac

Thirty-four members of the Fond du Lac County Medical Society met on February 26 for dinner at the Retlaw Hotel, Fond du Lac. Following the dinner they heard an address by Dr. Chester M. Kurtz, associate professor of medicine at the University of Wisconsin Medical School, who discussed "Cardiac Problems Commonly Encountered in Everyday Practice and How to Handle Them."

Jefferson

The monthly meeting of the Jefferson County Medical Society was held on March 19 at Lake Mills, commencing with a 6:30 dinner. The guest speaker was Dr. William S. Middleton, dean and professor of medicine of the University of Wisconsin Medical School, who spoke on "The Uses of Sulfonamide Drugs."

At a business session the members made further preparations for Civilian Defense to be carried out in their county.

La Crosse

Forty-five members of the La Crosse County Medical Society were present at their meeting at Hotel Linker, La Crosse, on March 17, to hear the guest speaker, Dr. Hartwick M. Stang of Eau Claire. His subject was "Urological Problems."

Marathon

Members of the Marathon County Medical Society were guests of Employers Mutuals of Wisconsin on February 24, for a dinner at the Wausau Club. The guest speaker was Dr. John S. Coulter, associate professor of physical therapy, at Northwestern University Medical School, who spoke on "Physical Therapy."

Preceding the dinner the group gathered at the newly equipped physical therapy department of Employers Mutuals in the Mayor–Lotz Building for an inspection of the rehabilitation work which is being done.

Marinette—Florence

Dr. Elmer L. Sevringhaus, professor of medicine at the University of Wisconsin Medical School, presented an address entitled "Problems of Obesity" to the members of the Marinette–Florence County Medical Society at their meeting on March 18 at Hotel Menominee. This was a joint meeting with the Menominee County Medical Society of Michigan. The scientific program was preceded by a 6:30 dinner.

Outagamie

Dr. Sumner L. Koch, associate professor of surgery at Northwestern University Medical School, was the guest speaker at the March meeting of the Outagamie County Medical Society, held at the Conway Hotel, Appleton, on the nineteenth. The title of his address was "The Treatment of Wounds."

The meeting began with a 6:30 dinner at the hotel, and was well attended.

Polk

Dr. George B. Noyes, Centuria, was host to members and guests of the Polk County Medical Society at a dinner at the LaBrant Hotel, Centuria, on February 19.

Following the dinner a scientific program was presented by two guest speakers from the University of Minnesota Medical School, Minneapolis. Dr. Ragnvald S. Ylvisaker, clinical assistant in medicine, presented a lecture on "Problems of the Gastrointestinal Tract: (A) What Is the Significance of Achlorhydria? (B) What Are Some of the Recent Trends in the Treatment of Peptic Ulcers?" The second speaker was Dr. Chauncey N. Borman, clinical assistant in radiology, who spoke on "Value of X-ray Examinations in Accurate Reductions of Fractures." Fourteen members and three guests were present.

At the March meeting, held at the Methodist Parish House, Frederic, guests and members of the Society were dinner guests of Dr. Karl F. Johnson of Frederic.

The subject of the discussion which followed the dinner was "The Effect of the Present War Upon the Polk County Medical Society." Members participating in the discussion and the respective phases of the subject discussed by each were as follows: Dr. Lien O. Simenstad, Osceola, explained defense as it relates to the doctors and hospitals of the county; Dr. Lorne A. Campbell, Clear Lake, explained some of the requirements for entering the Medical Naval Reserves; Dr. Henry C. Caldwell, St. Croix Falls, reminisced about the World War I as regards medical service; and Dr. Raymond G. Arveson, Frederic, explained some of the points relative to the Procurement and Assignment Service for physicians. A general discussion followed. Two guests and twelve members were present.

Racine

The regular monthly meeting of the Racine County Medical Society was held at the Elk's Club, Racine, on March 19. Dr. Frederick W. Madison, associate

clinical professor of medicine at Marquette University School of Medicine, was the guest speaker. The title of his address was "Hemorrhagic Diseases."

Rock

The Rock County Medical Society meeting on February 24 began with a dinner at Hotel Monterey, Janesville. Following the dinner a scientific program was presented:

A Discussion of Appendicitis—Dr. Wayne A. Munn, Janesville, program chairman

Summary of a County-Wide Survey of Appendicitis Cases—Dr. Thomas H. Flarity, Beloit

Diagnosis of Appendicitis—Dr. Orrin V. Overton, Janesville

General Practitioner's Problem in Appendix Cases—Dr. Thorn L. Vogel, Milton Junction

Physiology and Pathology of the Appendix—Dr. Russell F. Wilson, Beloit

Survey of Use of Sulfa Drugs in Appendicitis—Dr. Thomas J. Snodgrass, Janesville

Dr. Irwin R. Schmidt, professor of surgery at the University of Wisconsin Medical School, conducted a round-table discussion on the subject of appendicitis.

Sheboygan

Forty-five members were in attendance at the February meeting of the Sheboygan County Medical Society at the Sheboygan Memorial Hospital on the twenty-fourth. The scientific program included a discussion between a neurologist and a neurosurgeon on such phases as headaches, its various phases; epilepsy, brain hemorrhages and tumors, presented by Drs. Hans H. Reese, professor of neuropsychiatry, and Theodore C. Erickson, associate professor of surgery, both at the University of Wisconsin Medical School.

Another feature of the meeting was the presentation of a paper entitled "Medical Defense in Sheboygan County" by Dr. Fred A. Nause, Sheboygan.

Trempealeau—Jackson—Buffalo

The monthly meeting of the Trempealeau–Jackson–Buffalo County Medical Society was held at Arcadia Hotel, Arcadia, on March 19, commencing with a 6:30 dinner.

Mr. Charles H. Crownhart, secretary of the State Medical Society, discussed "Civilian Defense and Participation of the Physicians in This War Effort." Mr. George B. Larson, assistant secretary of the State Medical Society, showed and discussed the film strip "Health Achievements in Wisconsin," after which he discussed the availability of the exhibit for county fairs which was developed by the Committee on Health and Public Instruction of the State Medical Society.

At a business session the members voted to cooperate in Civilian Defense and sponsor a health exhibit at the county fair. In addition, the immunization program for the month of May was discussed and approved.

Thirteen members were in attendance at this meeting.

Walworth

Members of the Walworth County Medical Society and members of the Auxiliary met at the Walworth County Hospital for dinner on March 5. Following the dinner a discussion took place which dealt with the part the profession will play in the Civilian Defense organization.

Dr. Charles E. Pechous, Kenosha, councilor for the second district, described the manner in which the medical men and nurses take part in the organization of Civilian Defense. Dr. Edwin J. Schneller, Racine, and Dr. Cyril G. Richards, Kenosha, described what had been done by the groups in their counties.

Washington—Ozaukee

Members of the Washington–Ozaukee County Medical Society held their monthly meeting at St. Joseph Hospital, West Bend, on February 26. Drs. Phillip M. Kauth, West Bend, and Clifford H. Kalb, Grafton, discussed medicine in Civilian Defense. There were fifteen members present.

Winnebago

A dinner meeting was held at the Menasha Hotel, Menasha, on March 12, by members of the Winnebago County Medical Society. Following the dinner a scientific program was presented which consisted of a symposium on cancer, by the Cancer Committee, based on cases at Theda Clark and Mercy Hospitals. Those participating in the symposium were Drs. Marvin H. Steen, Oshkosh, chairman; Ronald B. Rogers, Neenah; Richard A. Jensen, Menasha; Milton J. Donkle, Oshkosh; and Samuel R. Beatty, Oshkosh.

Milwaukee Academy of Medicine

Dr. Edgar S. Gordon, assistant professor of physiological chemistry and research associate in medicine, University of Wisconsin Medical School, addressed members of the Milwaukee Academy of Medicine at their meeting at the University Club on March 17. The title of his lecture was "Debunking the Vitamins."

At this meeting it was announced by the Society that medical graduates of Milwaukee County since 1931 are eligible to enter a prize essay contest being sponsored.

Milwaukee Neuropsychiatric Society

The regular monthly meeting of the Milwaukee Neuropsychiatric Society was held at the University Club on February 26, beginning with a 6:30 dinner. The guest speaker was Dr. Milton H. Erickson, director of psychiatric research at the Wayne County Institutions at Eloise, Michigan. Dr. Erickson discussed hypnosis and its practicability in many types of psychiatric problems, both for ambulatory and hospital patients.

Milwaukee Oto-Ophthalmic Society

The regular meeting of the Milwaukee Oto-Ophthalmic Society was held at the University Club on March 10, commencing with a 6:30 dinner. The scientific program which followed comprised two papers by guest speakers. Dr. Anderson C. Hilding, Duluth, Minnesota gave a lecture entitled "The Ciliary System of the Respiratory Tract," and Dr. James H. Maxwell, assistant professor of otolaryngology at the University of Michigan Medical School, Ann Arbor, presented a paper entitled "Complications of Paranasal Sinus Disease."

Wisconsin Chapter, International College of Surgeons and the Milwaukee Society of Clinical Surgery

At a joint meeting of the Wisconsin Chapter of the International College of Surgeons and the Milwaukee Society of Clinical Surgery, held at St. Luke's Hospital, Milwaukee, on March 24, the following program was enjoyed:

SURGICAL CLINICS

ROOM 1

A. M.
9:00 James G. Garland, M. D.
10:00 Joseph J. Gramling, M. D.
11:00 William J. Carson, M. D.

ROOM 2

9:00 Joseph J. Adamkiewicz, M. D.
10:00 Roman E. Galasinski, M. D.
11:00 Gervase S. Flaherty, M. D.

ROOM 3. EYE, EAR, NOSE AND THROAT

9:00 Frank J. Schubert, M. D.
10:00 Edward M. Rice, M. D.
11:00 Bernard P. Churchill, M. D. Bronchoscopy

ROOM 4. UROLOGICAL SURGERY

9:00 Robert S. Irwin, M. D.
10:30 Walter M. Kearns, M. D.

ROOM 5. BONE AND JOINT SURGERY

9:00 John O. Dieterle, M. D.
10:00 Jaros F. Zivnuska, M. D.
11:00 Lemuel D. Smith, M. .

X-RAY LABORATORY

10:00 "The Use of X-ray in Localizing Foreign Bodies" —John E. Habbe, M. D.
11:00 "The Value of X-ray During Operations"—Hobart H. Wright, M. D.

PATHOLOGY LABORATORY

10:00 "The Laboratory Assistance in Traumatic Surgery"—Edward L. Tharinger, M. D.
11:00 "The Pathologist's Views on Appendicitis"—Leander J. Van Hecke, M. D.

DELIVERY ROOMS—SECOND FLOOR

9:00 "Obstetrical Surgery"—Elmer H. Gramling, M. D.
11:00 Rudolph W. Roethke, M. D.
P. M.
1:15 Luncheon at the University Club
2:30 "Surgery in Biliary Diseases"—Allen S. White, M. D., Rice Lake
"Digitalis in the Treatment of Wounds"—Karl F. Schlaepfer, M. D.
"Dysphagia"—Samuel G. Higgins, M. D.; Gerhard D. Straus, M. D.
6:00 Dinner at the University Club
7:15 "The Acute Gallbladder"—Clark D. Brooks, M. D., associate professor of clinical surgery, Wayne University College of Medicine, Detroit

NEWS ITEMS AND PERSONALS

The Fifteenth Annual William Snow Miller Lecture was given this year by *Dr. Edgar M. End*, instructor in physiology at Marquette University School of Medicine, on March 24, in Service Memorial Institutes, University of Wisconsin Medical School. The title of his address was "Some Recent Advances in Our Knowledge of Respiration and Their Application in Respiration Therapy."

This lectureship, which is sponsored by Phi Beta Pi Fraternity, is the oldest established by a medical fraternity and was founded in honor of the late Dr. William Snow Miller, who was famous for his research on the anatomy of the lung.

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Dr. Gjermund Hoyme, Eau Claire, was re-elected to the Board of Directors, and *Dr. Fin G. Anderson*, Eau Claire, was re-appointed to the Advisory Board of Lutheran Hospital Association, Eau Claire, at the twenty-seventh annual meeting held on February 24.

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Dr. Harvey C. Slocum, instructor in anesthesia at the University of Wisconsin Medical School for the last two years, left this position on April 1 to accept an appointment as professor of anesthesiology at the University of Texas School of Medicine and director of the Department of Anesthesia, The John Sealy Hospital, Galveston, Texas.

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Dr. Joseph J. Kronzer, Oshkosh, recently appointed sponsor for the National Recreation Association in that city, spoke to the members of the association recently, saying "In the long pull ahead, recreation is fundamental in keeping children normal, in developing youth, in relieving war strain on men and women." *Dr. Kronzer* is one of 300 volunteers serving the association in this capacity in principal cities throughout the country.

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Dr. Elmer L. Sevringhaus, professor of medicine at the University of Wisconsin Medical School, gave an illustrated lecture entitled "Sexual Development and Sex Instruction of Children" at the Shorewood Hills School auditorium, Madison, on March 2.

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Dr. William D. Stovall, professor of hygiene and clinical pathologist at the University of Wisconsin

Medical School, and director of the State Laboratory of Hygiene, lectured on cancer before a gathering at the City Hall auditorium in Evansville on February 19. On March 9 *Dr. Stovall* spoke before the Kiwanis Club, Madison, on the subject of cancer.

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Dr. Arnold S. Jackson, Madison, addressed members of the Southeastern Surgical Congress in Atlanta, Georgia, on March 9, speaking on the subject "Chemotherapy as an Adjunct to Surgery, With a Report on Sulfathiazole Used Intraperitoneally."

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A lecture sponsored by the Nu Sigma Nu professional medical fraternity was presented at Service Memorial Institutes, University of Wisconsin Medical School, on March 6, with Dr. Walter C. Alvarez, professor of medicine at the Mayo Foundation, Rochester, speaking on "Hints in Handling the Nervous Patient."

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Dr. E. R. Krumbiegel, Milwaukee, discussed "First Aid in Defense" at the dinner meeting of the Zonta Club, held on February 26.

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Dr. Herman A. Heise, Milwaukee, led a panel discussion on "Scientific Tests in the Prosecution of Intoxicated Drivers," at the meeting of the attorneys' section of the League of Wisconsin Municipalities in Milwaukee on February 27. He also addressed members of the Rock County Bar Association at their annual spring banquet held on March 23 at Janesville, his title being "How Drunk Am I?"

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Dr. Haldor Barnes, Marinette, has been named Marinette county physician by the Marinette County Board of Supervisors, to finish the unexpired term of the late *Dr. Maurice D. Bird.*

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Dr. Richard A. Jensen, Menasha, on March 17, delivered the lecture in the tenth of a series of fourteen refresher courses for registered nurses being given at the Theda Clark Memorial Hospital Nurses' Home, Neenah. The title of his lecture was "Nursing Care in Diseases of the Urinary Tract."

The remainder of the lectures will be presented by *Drs. Raymond H. Quade, Harold L. Baxter, John P. Canavan,* and *Samuel R. Beatty,* all of Neenah.

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Drs. Elmer L. Sevringhaus, professor of medicine at the University of Wisconsin Medical School; *Carl N. Neupert,* assistant state health officer; and *Clair O. Vingom,* chairman of the Health and Welfare Section of the Dane County Council of Defense, participated in the program presented in Agricultural Hall on the University of Wisconsin campus, on March 19 and 20, which was sponsored by the Dane County Nutrition Committee. This committee is a division of the Health and Welfare Section of the State Council of Defense. The importance of proper nutrition as a defense measure was the general theme of the discussions.

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Dr. Eben J. Carey, dean and professor and director of the department of anatomy, Marquette University School of Medicine, presented a paper entitled "Effects of Acute Starvation on Ameboid Motion of Motor Nerve Plates in Striped Muscle," at the annual meeting of the American Association of Anatomists, held on April 1, 2 and 3, in New York City.

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Dr. Oscar Lotz, executive secretary of the Wisconsin Anti-Tuberculosis Association, announced recently that the Dearholt Memorial Fund will be maintained permanently. Tuberculosis institutes at Marquette University School of Medicine and the University of Wisconsin Medical School, as well as at sanatoria throughout the state, are made available by the Dearholt Memorial Fund. *Dr. Hoyt E. Dearholt,* who died in 1939, originally started this fund by making deductions from his salary as secretary for the association.

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Drs. Homer M. Carter, Horace K. Tenney, and *Frank L. Weston* of Madison, and *Drs. M. G. Peterman* and *Samuel E. Kohn* of Milwaukee, attended the meeting of the Chicago Pediatric Society, which was held at Children's Memorial Hospital in Chicago on March 17.

W. C. Keettel, M. D., Bureau of Maternal and Child Health, State Board of Health, Madison

OBSTETRICAL MANIKIN DEMONSTRATIONS

Throughout each day of the Spring Postgraduate Clinics

Chippewa Falls, April 27—Wausau, April 28—Fond du Lac, April 29

THE PRESS

Jury Convicts Chiropractors*

Sentence, Motions, Are Scheduled For April 1

AFTER deliberating two hours and five minutes, a Janesville municipal court jury at 5:15 p. m. Friday returned a verdict of guilty in the case of two Janesville chiropractors charged with practicing without the required credentials.

The two convicted are man and wife, A. G. Mork, 30, and Esther Kumbier Mork, 30, both of 409 E. Milwaukee street. Judge Ernest P. Agnew, before whom the case was tried, set April 1 at 10 a. m. as the time for hearing motions and passing sentence. A decision is expected at that time on a defense motion to quash the indictment on the grounds that the law is unconstitutional.

Ward Is Jury Foreman

C. H. Ward was foreman of the jury which returned the verdict of guilty. In the midst of deliberations, jurors returned for further information from Judge Agnew, to learn the names of members of the state board of examiners in chiropractic.

The Morks were charged specifically with practicing as chiropractors and holding themselves out to do so, without having a certificate of registration in the basic sciences, or a license from the state board of examiners in chiropractic, or having either on file with the county clerk as required by the law.

The defense made no effort to show that the Morks did have proper credentials; it based its hope of acquittal on claims that the medical profession makes it too difficult for chiropractors to obtain certificates and licenses, on a showing that the Morks are of good reputation and character, and on a plea for sympathy. In fact it was admitted that Mr. Mork wrote an examination several years ago and failed it.

Doctors Criticized

"These people are charged with a crime because they could not pass an examination handed down by the M. D.'s," George Murwin, defense attorney, told the jury in his closing argument. "The state law in Wisconsin prohibits chiropractors from using the title of doctor.

"Yet the medical profession and doctors are passing on whether they can be chiropractors or not.

"Here we have one group treating the sick not only regulated but dominated by another group treating the sick. This is a case of persecution rather than prosecution," Murwin said.

Dist. Atty. Howard H. Moss told the jury in his final talk that anyone treating the sick should be made to meet some minimum standards for the protection of the public. "If this law is not upheld, then I could go out and practice as a chiropractor," Mr. Moss said.

"I am required to pass the bar examination before I can practice law. And if I fail it, I don't go out and practice anyway and criticize the law; I go back and study until I can pass it."

The defendants in the case, Mr. and Mrs. Mork, sat with their attorneys throughout the trial, but did not take the stand.

Principal witness for the defense was A. W. Ponath, Madison attorney, who heads a nation-wide movement of Freedom to Treat the Sick. He quoted from some of his own publications in an effort to show that the medical profession does not treat chiropractors fairly.

Complainant on Stand

The defense also called as one of its witnesses Steve Gavin, Madison attorney, who assisted Dist. Atty. Howard H. Moss in prosecuting the case. Gavin, who is attorney for the state board of medical examiners, was the man who signed the complaint in the case against the Morks.

Character witnesses called by the defense were Arthur Olmstead, Mrs. John Marty, Mrs. Beatrice Tiffany, and Mrs. John Ryan.

The defense was assisted by George G. Rinier, Indianapolis, Ind., chiropractors' attorney.

The state, which completed its case during the morning, had called only three witnesses, Dolores Heinz, deputy register of deeds, who testified to taking treatments from both Mr. and Mrs. Mork; County Clerk Walter M. Lindemann, who testified no certificates for the Morks were on file in his office; and Police Officer Hilton West, who testified that the Morks advertised themselves as chiropractors.

Gavin commented after the trial that he has been instrumental in several prosecutions of Wisconsin chiropractors who have not obtained the proper credentials. He said he has given all of them a chance to pass examinations and secure the necessary certificate in the basic sciences before starting prosecution. Only one other practicing chiropractor in Janesville has failed to qualify, Gavin said.

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* Reprinted from *Janesville Gazette*, March 21, 1942.

SOCIETY RECORDS

New Members

J. G. Russo, Wisconsin State Sanatorium, Statesan.

E. M. Randall, Prairie du Sac.

C. K. Kincaid, Court House Annex, Eau Claire.

C. A. DeWitt, Silver Lake.

W. J. Schutz, National Bank Building, Shawano.

Milton Finn, Board of Trade Building, Superior.

M. T. Morrison, South Wayne.

L. T. Kent, 623 Fifty-eighth Street, Kenosha.

Sarah D. Rosekrans, Neillsville.

J. M. Rose, 1531 Main Street, Marinette.

Changes in Address

H. C. Slocum, Madison, to Department of Anesthesia, University of Texas School of Medicine, Galveston, Tex.

S. S. Blankstein, Springfield, Mo., to 606 West Wisconsin Avenue, Milwaukee.

R. J. Rogers, Westchester, Ill., to 1004 North Eighteenth Street, Melrose Park, Ill.

F. J. Erdlitz, Oshkosh, to Peshtigo.

L. M. Cox, New York, N. Y., to 1521 West Sherwin Avenue, Chicago, Ill.

MARRIAGES

Dr. Alvin M. Shapiro and Miss Berdie Borenstein, both of Milwaukee, on March 1, at Milwaukee.

BIRTHS

A daughter, Susan Mary, to Dr. and Mrs. M. F. Greiber, Madison, on February 26.

A daughter to Dr. and Mrs. E. R. Krumbiegel, Milwaukee, on February 26.

DEATHS

Dr. Rock Sleyster, at the age of 62, died at his home in Wauwatosa, on March 7. Although he had been suffering from a heart ailment for some time, he had seen patients in his office the day previous to his death.

A native of Wisconsin, Dr. Sleyster was born at Waupun on June 14, 1879. He received his early education in the Waupun city school system and the Appleton High School. He entered the College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, for the study of medicine, and was graduated in 1902. He began the practice of medicine at Kiel, where he remained for five years. For the following two years he practiced at Appleton.

In 1908 he was named physician at the Wisconsin State Prison, a position he held until 1913. That year he was appointed to direct the building of the hospital for the criminal insane at Waupun, now known as the Central State Hospital for Insane, and later he became medical superintendent of the hospital. He resigned this position in 1919 to become medical director of the Milwaukee Sanitarium, Wauwatosa, which post he held until his death. He was one of the nation's leading specialists in psychiatry.

The only Wisconsin doctor ever to hold the office of president of the American Medical Association, in 1938 he was chosen president-elect of the Association, which office automatically carries with it succession to the presidency the following year. He assumed the office of president on May 16, 1939 at the American Medical Association convention in St. Louis, at which was present a large delegation of Milwaukee and Wisconsin physicians. This honor followed twenty-six years of continuous service to the Association in one office or another.

Dr. Sleyster's prominence in medical organization began early in his medical career, when he became secretary of the Calumet County Medical Society while practicing at Kiel. In 1910 he was elected assistant secretary of the State Medical Society of Wisconsin and served in this office until 1914, when he became secretary. This position he occupied until he was elected president in 1924. The following year he became treasurer of the Society and served until 1939. He was editor of *The Wisconsin Medical Journal* from 1918 to 1923.

Simultaneous with his official capacities in the State Medical Society, he was active officially in the American Medical Association. In 1913 and 1914 and from 1918 to 1926 he served as delegate to the American Medical Association, and from 1922 to 1926 he was vice-speaker of the House of Delegates. He became a trustee of the American Medical Association in 1926, which office he held until 1937, acting as chairman of the Board from 1935 to 1937. In addition, he served on several of the American Medical Association councils from 1936 to 1938.

From 1916 to 1920 he served as chief of the Bureau of Post-Graduate Medical Instruction at the University of Wisconsin Extension Division. During World War I he was a major in the United States Army Medical Corps and was appointed medical aide to Governor Philipp.

That Dr. Sleyster's devotion to his profession and its members was recognized and appreciated is evidenced by the honors bestowed upon him. In 1934 he was given the Council Award, the gold seal of the State Medical Society of Wisconsin, for "devotion to the individual needs of the mentally sick." A testimonial dinner was given for him by the Medical Society of Milwaukee County on November 14, 1936 at the Wisconsin Club, Milwaukee. In recognition of his contributions to medical education, the degree of LL.D. was conferred upon him by Marquette University School of Medicine in 1941.

His affiliations with medical societies were numerous. He was a fellow and a member of the Board of Governors of the American College of Physicians, and a member of the Board of Directors of the Wisconsin Anti-Tuberculosis Association and the National Tuberculosis Association. He was a member of the Milwaukee Academy of Medicine, the

Milwaukee Neuro-psychiatric Society, the Chicago Neurological Society, the Chicago Medical Society, the Chicago Institute of Medicine, the American Psychiatric Society, the Association for Research in Nervous and Mental Diseases, the Central Neuropsychiatric Association, the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow, and one sister, Mrs. Henry Hollen of Los Angeles.

Dr. Ralph M. Carter, Green Bay, was born in 1894, and died at his home on March 24, at the age of 58.

He received his A. B. degree from the University of Illinois in 1905 and his M. D. degree from Rush Medical College in 1908. He served his internship at Cook County Hospital, Chicago, and later did postgraduate work in various European clinics in orthopedics and bone surgery. Dr. Carter began the practice of medicine in Green Bay in 1910, and served as attending surgeon of St. Mary's Hospital, St. Vincent's Hospital, and Bellin Memorial Hospital, Green Bay.

He held memberships in numerous state and national medical organizations, including the Brown–Kewaunee–Door County Medical Society, State Medical Society of Wisconsin, American Medical Association, Green Bay Academy of Medicine, Wisconsin Surgical Club, American College of Surgeons, Clinical Orthopedic Society, Association of Railway Surgeons, American Board of Surgery, American Academy of Orthopedic Surgeons, American Board of Orthopedic Surgery, American Association for the Surgery of Trauma, and Western Surgical Association.

During Dr. Carter's medical career he was honored by having conferred upon him offices in many of the medical societies to which he belonged. He was formerly president of the Brown–Kewaunee–Door County Medical Society, Green Bay Academy of Medicine, Fox River Valley Medical Society, and State Medical Society of Wisconsin. He also served as speaker of the House of Delegates of the State Society.

He is survived by his widow; a daughter, Mrs. Calvin Elwood, Rochester, New York; two grandchildren, and one sister, Mrs. Ralph Prescott, Decatur, Illinois.

Dr. Maurice D. Bird, Marinette, at the age of 69, died at his home on March 13, after a long illness from heart disease.

A native of Wisconsin, Dr. Bird was born in Sun Prairie on May 12, 1872. His early education was obtained in the Sun Prairie city schools and the Sun Prairie High School. He was graduated from the University of Wisconsin in 1892 and from Rush Medical College in 1896. After completion of his medical training he served as house physician at Waldheim Sanatorium in Oconomowoc for a year before going to Marinette, where he maintained a medical practice until his death, and was county physician.

Dr. Bird was a member of the Marinette–Florence County Medical Society, a life member of the State Medical Society of Wisconsin, a fellow and member of the American Medical Association, and a fellow of the American College of Surgeons. He served as surgeon for the Chicago, Milwaukee, St. Paul and Pacific Railroad. When the Marinette and Menominee Hospital Company was in existence he served as its president.

Dr. Bird held offices in both the County and State Medical Societies. He served as secretary of the Marinette–Florence County Medical Society from 1911 to 1914 and from 1923 to 1930. In the State Society he was alternate delegate to the American Medical Association from 1929 to 1934 and was vice-speaker of the House of Delegates in 1931.

Surviving him are his widow, a sister, Mrs. P. A. Martineau of Marinette, and a nephew, Louis B. Schulting of Passaic, New Jersey.

Dr. John P. Hornig, Cedarburg, former Grafton physician, died at the home of his daughter, Mrs. E. W. Paulus, Cedarburg, on February 28.

Dr. Hornig obtained his medical training at Wisconsin College of Physicians and Surgeons in Milwaukee, from which he was graduated in 1901. After practicing in Milwaukee for two years Dr. Hornig established a practice at Grafton, where he remained until his retirement a few years ago. Since then he had been making his home in Cedarburg.

Surviving him are his widow; three daughters, Mrs. Paulus, Mrs. William Holl of Germantown, and Mrs. Franklin Seifert of Theinsville; a son, Hugo of Cedarburg; two brothers, Fred of Milwaukee, and Charles of Hartland; a sister, Mrs. William Gastel of Milwaukee; and six grandchildren.

Dr. Asa E. Dillman, Steuben, died at the home of his son, F. E. Dillman, on February 26, after a year's illness. He was 83 years of age.

Dr. Dillman who had practiced medicine for the past fifty years had spent most of that time in the Kickapoo Valley, where he was both physician and friend to hundreds of families.

He obtained his medical education at the Medical University of Ohio, from which he was graduated in 1890. He continued in the practice of medicine until a year ago when he became ill and retired. He was a life member of the Crawford County Medical Society and a member of the State Medical Society and the American Medical Association.

Dr. Barnard J. Rothberg, Hayward, died on February 19, at the Hayward Indian Hospital, from injuries received in an automobile accident when returning to Hayward from the Indian Reservation. He was 34 years of age.

Dr. Rothberg was field physician for the Great Lakes Indian Agency on the Lac Courte Oreilles Reservation, Sawyer County, near Hayward. He obtained his medical training in Switzerland, receiving his M. D. degree there in 1936.

Surviving him are his widow, and a brother in Boston.

Dr. Franz Pfister, Milwaukee, died in his hotel room, on March 2, of pneumonia after an illness of about two weeks.

Dr. Pfister was born in Innsbruck, Austria in 1861. While still a young boy he came to America and made his home in Milwaukee, where he received his preliminary and secondary education. He was graduated from Western Reserve University School of Medicine, Cleveland, in 1895. After practicing in Milwaukee for a short time, he went to Vienna, Austria, for continued medical study in preparation for a specialty in ear, nose and throat. On his return he re-established his practice in Milwaukee, specializing in ear, nose and throat. Although he was 81 years old, it was not until shortly before his illness that he gave up his medical practice. In connection with his practice in ear, nose and throat he also was associated with Marquette University School of Medicine in teaching in this field, serving at one time as director of the department.

Greatly interested in physical education, Dr. Pfister taught physical education in public schools prior to and while studying medicine. In this interest also, he was editor of *Mind and Body*, a journal of physical training for schools.

In his early career, because of his special interest and extensive study of physical education and orthopedics, Dr. Pfister frequently was called upon by the schools to correct abnormal spinal conditions among students. It was in this connection that Douglas MacArthur, now commander of the southwestern Pacific United Nations' forces, consulted him for correction of a spinal ailment which prevented him from satisfactorily passing a physical examination for entrance into The West Point Military Academy. After a regimen of treatment under the direction of Dr. Pfister, this ailment was corrected and Douglas MacArthur passed the required physical examination and was admitted to The West Point Military Academy.

Dr. Pfister was a charter member of the American College of Surgeons, and formerly held membership in the Medical Society of Milwaukee County of which he was president in 1918, the State Medical Society of Wisconsin and the American Medical Association.

Surviving him are his sisters, Marie of Innsbruck, Austria, and Katie Meyer and Rose Unger of Munich, Germany.

Coming Events

University of Wisconsin Medical School Schedule of Saturday Morning Clinics

Apr. 18. Surgery: Surgical Diseases of the Rectum. Dr. Lemmer and Associates

Apr. 25. Medicine: Medical-Surgical Coordination in the Treatment of Pulmonary Tuberculosis. Dr. Oatway and Associates

May 2. Orthopedics: Bone Grafting. Dr. Burns and Associates

May 9. Obstetrics and Gynecology: Therapeutic Procedures in Ambulatory Gynecological Patients — Demonstrations. Dr. Harper and Associates

May 16. Pediatrics: Manifestations of Tuberculosis in Infancy and Early Childhood. Dr. McDonough and Associates

May 23. Surgery: Fractures of the Back from a Neurosurgeon's Viewpoint. Dr. T. C. Erickson

May 30. Medicine: Clinical Avitaminosis. Dr. Gordon and Associates

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University of Wisconsin Medical School Postgraduate Courses for General Practitioners— April 20 to April 24, 1942

MEDICINE

Monday

Diseases of the Blood and Blood-forming Organs. Dr. Meyer and Associates

1. Hemorrhagic Diseases
2. Diseases of the Lymph Nodes
3. Anemias—Their Differentiation and Management

Tuesday

Diseases of the Digestive Tract. Dr. Puestow and Associates

1. Diseases of the Liver
2. Peptic Ulcer
3. Regional Ileitis and Colitis

Wednesday

Diseases of the Endocrine Glands. Dr. Sevringhaus and Associates

1. Diseases of Thyroid Gland
2. Diabetes Mellitus
3. Diseases of Parathyroid Gland
4. Diseases of Adrenal Bodies
5. Diseases of Ovary and Testis
6. Pituitary and Growth

Thursday

Vitamins and Minerals. Dr. Gordon and Associates

Friday

Diseases of the Circulatory System. Dr. Kurtz and Associates

1. Arrhythmias
2. Coronary heart disease
3. Cardiac drugs

SURGERY

Monday

Surgery of the Breast. Dr. Schmidt and Staff

1. Anatomy in the Dissecting Room
2. Symptoms of Benign and Malignant Tumors
3. Pathology and Slides
4. Discussion of Surgery
5. Radiation Therapy

Tuesday

Surgery of the Gallbladder. Dr. Gale and Staff

1. Anatomical Laboratory
2. Symptoms and Findings (Physical and Laboratory)
3. Surgery and Post-operative Complications

Wednesday
Common Fractures. Dr. Burns and Staff
1. Anatomical Laboratory
2. Discussion and Treatment of Common Fractures with X-ray and Patient Demonstrations

Thursday
Empyema. Dr. Curreri and Staff
1. Anatomical Laboratory
2. Pathological Physiology in Empyema
3. Diagnosis and Treatment

Friday
Hernia. Dr. Lemmer and Staff
1. Anatomical Laboratory
2. Discussion of Hernia
3. Treatment: Radical vs. Conservative
4. Post-operative Complications

PEDIATRICS

Monday
Diseases of the Newborn Infant Including Care of the Premature. Dr. Gonce and Associates

Tuesday
Nutritional Disturbances of Infancy. Dr. Tenney and Associates

Wednesday
Common and Uncommon Causes of Disturbances of Growth in Infancy and Childhood. Dr. McDonough and Associates

Thursday
Congenital Defects. Dr. Gonce and Associates

Friday
Diagnosis and Treatment of Acute and Chronic Skin Condition in Infancy and Childhood (Including Burns). Dr. Tenney and Associates

OBSTETRICS AND GYNECOLOGY

Monday
Introduction and Outline of Course
Pelvimetry—Demonstrations and Discussion
Operative Obstetrics—Manikin Demonstrations
Dr. Harris and Associates

Tuesday
The Treatment of Some Common Complications of Pregnancy
The Management of Abortion and Premature Labor
Ward Rounds and Clinical Conference
Dr. Harris and Associates

Wednesday
The Conduct of Normal Labor—Demonstrations
Pain Relief in Labor—Demonstration of Methods
Ward Rounds and Clinical Conference
Dr. Harris and Associates

Thursday
The Management of the Puerperium
Postpartum Hemorrhage; Causes, Prevention and Treatment
Ward Rounds and Clinical Conference
Dr. Harris and Associates

Friday
Gynecologic Problems
Office Gynecology—Demonstrations
Ward Rounds and Clinical Conference
Dr. Harris and Associates

ROUND-TABLE LUNCHEONS

(Cost included in registration fee)

Monday—Medicine
Tuesday—Pediatrics
Wednesday—Surgery
Thursday—Orthopedics
Friday—Obstetrics and Gynecology

Milwaukee Children's Hospital—Schedule of Clinical Presentations

The staff of the Milwaukee Children's Hospital has arranged a schedule of clinical presentations for the coming months. A tentative partial program follows. The time of the clinical presentations will be from 12:30 to 1:30 p.m. Dr. Arthur A. Schaefer will direct the surgical clinics, Dr. Walter P. Blount the fracture service clinics, and Dr. A. L. Kastner the pediatric clinics.

APRIL

Fracture Service Clinic, Tuesday, April 14
Out-Patient Clinic
Pediatric Clinic, Friday, April 17
Electroencephalogram. Discussion by Niels L. Low, M. D., Milwaukee
Surgical Clinic, Monday, April 20
Presentation of Cases. Discussion of Surgical Lesions of Neck
Fracture Service Clinic, Tuesday, April 21
Out-Patient Clinic
Pediatric Clinic, Friday, April 24
Protein Metabolism. Discussion by L. E. Booher, Ph. D., Milwaukee
Surgical Clinic, Monday, April 27
Presentation of Cases. Discussion of Branchial and Thyroglossal Cysts.
Fracture Service Clinic, Tuesday, April 28
Out-Patient Clinic

MAY

Pediatric Clinic, Friday, May 1
Communicable Diseases. Discussion by Max J. Fox, M. D., Milwaukee
Pediatric Clinic, Friday, May 8
Nutrition Question-Box. L. E. Booher, Ph. D., Milwaukee
Pediatric Clinic, Friday, May 15
Presentation of Interesting Cases.

—△—

Examinations—American Board of Obstetrics and Gynecology

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted at Atlantic City, N. J., by the entire Board, from Thursday, June 4, through Tuesday, June 9, 1942, prior to the opening of the annual meeting of the American Medical Association.

Group A, Part II, candidates will be scheduled for examination the first part of the examination period, and Group B, Part II, the latter half. Formal notice of the time and place of these examinations will be sent each candidate several weeks in advance of the examination dates.

Candidates for *reexamination* in Part II must make written application to the secretary's office before April 15, 1942.

As previously announced in the Board booklet, this fiscal year (1941–1942) of the Board marks the close of the two groups of classification of applicants for examination. Thereafter, the Board will have only one classification of candidates, and all will be required to take the Part I and Part II examinations.

(Continued on page 344)

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The Board requests that all prospective candidates who plan to submit applications in the near future request and use the new application form which has this year been inaugurated by the Board. The secretary will be glad to furnish these forms upon request, together with information regarding Board requirements. Address Dr. Paul Titus, secretary, 1015 Highland Building, Pittsburgh, Pennsylvania.

— △ —

American College of Surgeons—War Session—Hospital Conference, Wisconsin

Monday, May 4, 1942

Hotel Loraine—Madison

PROGRAM

9:00–10:30 a.m.

J. S. Supernaw, M. D., Madison; chief of Emergency Medical Service, Dane County Council of Defense; member, Wisconsin State Committee on Emergency Medical Service, Presiding.

Forum: Civilian Defense as Related to Hospital

Led by Regional Medical Officer, United States Office of Civilian Defense

10:45 a.m.–12:15 p.m.

Joint Meeting, Physicians, Surgeons, and Hospital Representatives

The Organization and Functions of the Medical Department of the United States Army

The Organization and Functions of the Medical Department of the United States Navy

The Doctor and the Hospital in Civilian Defense

12:30–2:00 p.m.

Joint Luncheon, Physicians, Surgeons, and Hospital Representatives

Address: The Procurement and Assignment Service

2:15–5:00 p.m.

Panel Discussion: Special Problems Incident to the War as Affecting Hospitals

Opening Statement. Hospitals and the War

Organization of the Hospital for Civilian Defense

Relation of the Procurement and Assignment Service to the Hospital

Priorities, and the Problem of Obtaining Hospital Equipment, Furnishings, and Supplies Essential to Rendering Adequate Services

Maintaining Adequate Professional and Non-professional Personnel Owing to Enlistment in the Military Services and Industrial Expansion

Meeting the Increasing Costs of Hospital Service

Conservation During Wartime, as Applying to Hospital Personnel, Labor and Supplies of All Kinds

6:00–7:30 p.m.

Dinner: Physicians, Surgeons, and Hospital Representatives

7:30–8:00 p.m.

Activities of the American College of Surgeons and Their Relation to the Defense Program

8:00–10:00 p.m.

Panel Discussions:

Treatment of Burns

Prevention and Treatment of Shock

Annual Meeting Program—Wisconsin Anti-Tuberculosis Association

Schroeder Hotel, Milwaukee

April 17–18

FRIDAY

A.M.

9:00 Registration

10:00 W.A.T.A. business meeting

Highlighting the last year and a glimpse at the future—

Oscar Lotz, M. D., executive secretary

P.M.

1:30 The Man the Army Doesn't Want—

Major Paul Eisele, senior officer, U. S. Army Examining Station

E. F. Jorris, M. D., director, Tuberculosis Division, State Board of Health

F. E. MacInnis, M. D., director, Tuberculosis Division, Milwaukee Health Department

Aunt Lucy Learns About Tuberculosis—

Viola Turney, Milwaukee, second prize winner, National Tuberculosis Association Negro essay contest

A New Lever in Control Machinery—

Karl Pfeutze, M. D., superintendent, Mineral Springs Sanatorium, Minnesota

7:00 Dinner

Tuberculosis Control and National Defense—

Herman E. Hilleboe, M. D., surgeon in charge of tuberculosis control, U. S. Public Health Service

SATURDAY

A.M.

9:00 Cutting Corners on Tuberculosis Control—

I. F. Thompson, M. D., Racine health officer; A. A. Pleyte, M. D., medical department head, W.A.T.A.; Mrs. Ruth Gilfry, Stevens Point, Portage county nurse

The Tuberculosis-Free Factory—

Miss Frances Silbaugh, R. N., industrial nurse, Oscar Mayer & Co.

The Right Job For the Right Man—

Mr. Harold McGee, rehabilitation consultant, W.A.T.A.

— △ —

Friday Morning Clinics—1942

Milwaukee County Hospital and the Marquette University School of Medicine

Milwaukee

April 10

1. Uncommon causes of heart disease.
2. Eye injuries.

April 17

1. Practical aspects of physiotherapy.

April 24

1. Pleural effusion.
2. Chest injuries.

— △ —

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Two Weeks—August 17–August 29, 1942

By Dr. Louis N. Katz

Director of Cardiovascular Research

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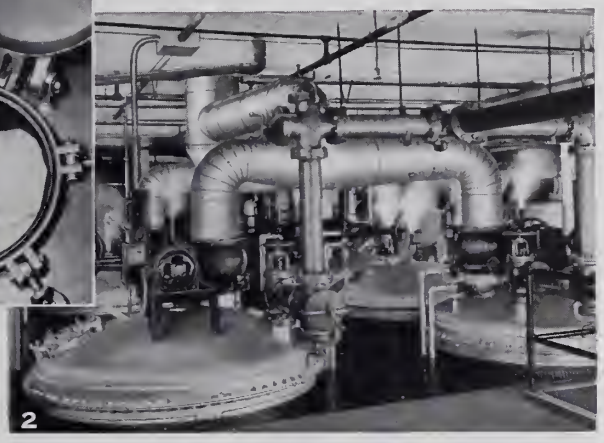

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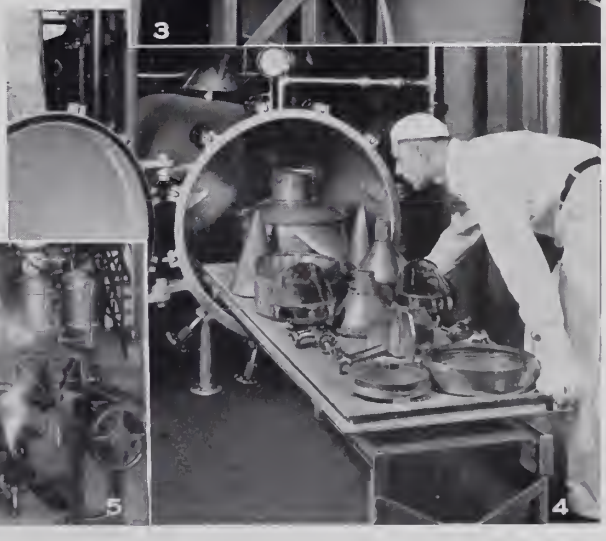

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Medicine
The Physician In War
at the
Spring
Postgraduate
Clinics

Chippewa Falls April 27
Wausau April 28
Fond du Lac April 29

Turn To . . .
page 326 for
information on
speakers and subjects

THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Synopsis of the Preparation and Aftercare of Surgical Patients. By Hugh C. Ilgenfritz, A. B., M. D., instructor in surgery, Louisiana State University School of Medicine; visiting surgeon, Charity Hospital of Louisiana at New Orleans, and Rawley M. Penick, Jr., Ph. B., M. D., F. A. C. S., professor of clinical surgery, Louisiana State University School of Medicine; visiting surgeon, Charity Hospital of Louisiana at New Orleans, with foreword by Urgan Maes, M. D., D. Sc., F. A. C. S., professor of surgery and director of the Department, Louisiana State University School of Medicine; senior visiting surgeon, Charity Hospital of Louisiana at New Orleans; consulting surgeon, Tuoro Infirmary. Cloth. Price $5. Pp. 532, with 55 illustrations. St. Louis: The C. V. Mosby Company, 1941.

This book is intended as a practical guide for the care of surgical patients. It, therefore, is a book that will prove of great value for residents, interns and surgeons for practical use and in reviewing for examinations. However, the discussion is not complete enough for its use as a text for students. The book is written in two sections. The first section is devoted to a general discussion of the preoperative and postoperative care of the patient, and the second section is devoted to a more detailed discussion of the care of the various surgical conditions. The reviewer believes this book is well worth-while for anyone planning to enter the surgical field. A. R. C.

From Cretin to Genius. By Dr. Serge Voronoff. Cloth. Price $2.75. Pp. 281. New York: Alliance Book Corporation, 1941.

The author believes that the fundamental qualities of geniuses are inherited and that their accomplishments are due primarily to the activities of a "subconscious" mind. These accomplishments ultimately manifest themselves in a "conscious" expression in the fields of literature, music, art, and science. He correlates the achievements of geniuses with greater development of a specific portion of the brain. For instance, the author believes that musicians have an hypertrophy of cells (presumably cortical) in the "auditory system" and distinguished writers an hypertrophy in Brocca's area. While this is an interesting theory, it is questionable whether sufficient histological studies of the brains of geniuses and non-geniuses have been made to substantiate the author's categorical statements.

Throughout the entire book one finds many dogmatic remarks, similar to the one cited above, which may reasonably be challenged. Probably the most

(Continued on page 349)

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Smith, Kline & French Laboratories, Philadelphia
Westinghouse X-Ray Division, Long Island City, N. Y.
Wisconsin Anti-Tuberculosis Association, Milwaukee

BOOK REVIEWS—Continued

interesting parts of this book are the numerous anecdotes of geniuses in music, mathematics, literature, and science. There are a number of interesting hypotheses which challenge the imagination but appear to be inadequately based on scientific observation. J. P.

The Medical Clinics of North America. Chicago Number, Volume 26, Number 1. Cloth. Price $16 per clinic year. Pp. 313, with 45 illustrations. Philadelphia: W. B. Saunders Company, January 1942.

Approximately two-thirds of this volume is devoted to common skin diseases. This portion includes chapters on lymphoblastoma cutis, contact dermatitis, vitamins in dermatology and ten others of practical value. The last portion of the book includes clinics on a variety of subjects, the most valuable probably being those in gynecologic office procedures, on the irritable colon, and common diseases of the respiratory tract in children.

The usual standard of these clinics and these volumes is maintained. However, commencing with this book, the binding has been changed with resultant improved appearance. Typographical changes have also enhanced the appearance and readability of the volume. O. O. M.

Cancer of the Face and Mouth; Diagnosis, Treatment, Surgical Repair. By Vilray P. Blair, M. D., Sherwood Moore, M. D., and Louis T. Byars, M. D. St. Louis. Cloth. Price $10. Pp. 599, with 324 illustrations including 64 plates. St. Louis: The C. V. Mosby Company, 1941.

This book contains a mass of illustrations of various malignancies of the face and mouth, and contains valuable information in the treatment thereof, especially from the standpoint of use of radium and x-ray. The photographs of postoperative results show cosmetic restorations which are excellent. However, unfortunately, the procedures used to obtain these results are not outlined except as one is able to follow the changes in appearance of these patients as further step operations. To the general practitioner, this book does at least give them an idea of what can be done towards curing and restoring what appear to be hopeless cases of cancer of the mouth and face. V. B. H.

Wounds and Fractures, A Clinical Guide to Civil and Military Practice. By H. Winnett Orr, M. D., F. A. C. S., chief surgeon, Nebraska Orthopedic Hospital, Fellow of the American College of Surgeons; member of the International Society of Orthopaedic Surgery, the American Orthopaedic Association, and the American Academy of Orthopaedic Surgeons. Cloth. Price $5. Pp. 227, with 137 illustrations. Springfield, Illinois. Charles C. Thomas, 1941.

In this book Dr. Orr summarizes his extensive work on fractures, simple and compound, recent and old; and his truly great steps in the treatment of

(Continued on page 350)

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BOOK REVIEWS—Continued

osteomyelitis. There are outlines of his cases and many illustrations of the procedures, deformities, and x-rays. In short, it is a book for fundamentals of treatment of wounds and fractures described to the end results, interestingly written.

The author wishes to impress his readers with the fact that all fractures should be treated alike following four cardinal principles; namely, traction, anatomic relationship, immobilization, and regard for ultimate function. He is primarily an exponent of fixed skeletal traction and infrequent dressings with debridement and vaseline packs. Throughout the book he stresses the fact that an essential part of the treatment of shock is the adequate treatment of any and all fractures. It is his opinion that there are too many open reductions of fractures carried out before adequate attempts at manipulation are made. Specifically, he states that no one who is unable to reduce a fracture of the neck of the femur by the Whitman maneuver should attempt to nail a hip.

The last portion of the book deals with physiotherapy and the pressure which is exerted by the physician to begin early motion of the joints in involved areas. It is his belief that stiffness of the joints, for example of wrist and hand, following removal of a cast are due, not to the time element involved, but to poor reduction and inadequate immobilization. S. C. R.

Occupational Diseases. Diagnosis, Medicolegal Aspects and Treatment. By Rutherford T. Johnstone, A. B., M. D., director of the department of occupational diseases, Golden State Hospital, Los Angeles, California; formerly assistant professor of medicine, University of Pittsburgh School of Medicine. Cloth. Price $7.50. Pp. 558, with 132 illustrations. Philadelphia: W. B. Saunders Company, 1941.

This book embodies the diagnosis and treatment, interpretation of the medicolegal aspects, and estimation of the duration and degree of expected disability of the common occupational diseases. The background of this work was derived, over a period of twenty-five years, from a large occupational disease clinic where the annual admissions now exceed 11,000 patients. It is practical, well written, well organized, and concise. The reader will not be equipped to deal with the more complex phases of the medicolegal aspects of this field, which require an expert, but he will avoid many of the pitfalls and common errors (mainly of omission) of adequate diagnosis and treatment. These mistakes and omissions become all too evident when the question of disability arises. No mention is made of aviation medicine. The bibliography is brief. The volume is well bound and fairly priced. It is not intended as an exhaustive reference book, but rather as a working aid for general practitioners and medical students. The author fulfills his aim and the book may be highly recommended. J. B.

The 1941 Year Book of Obstetrics and Gynecology. Edited by Joseph B. DeLee, A. M., M. D., professor of obstetrics, University of Chicago Medical School; chief of obstetrics, Chicago Lying-In Hospital and Dispensary, in affiliation with the University of Chicago; and J. P. Greenhill, B. S., M. D., F. A. C. S., professor of obstetrics and gynecology, Loyola University Medical School, Chicago; professor of gynecology, Cook County Graduate School of Medicine; attending gynecologist, Cook County Hospital. Cloth. Price $3. Pp. 704, with 144 illustrations. Chicago: The Year Book Publishers, Inc., 1941.

This is an excellent volume covering the important contributions to this field yearly. I do not hesitate to recommend it to those interested in gynecology and obstetrics. R. E. C.

The Toxemias of Pregnancy: By William J. Dieckmann, M. D., associate professor of obstetrics and gynecology, The University of Chicago; attending obstetrician, The Chicago Lying-in Hospital and Dispensary; attending gynecologist, Albert Merrit Billings Memorial Hospital of the University of Chicago; associate editor of the American Journal of Obstetrics and Gynecology; co-chairman of the Conference on Eclampsia, United States Department of Labor, Children's Bureau, 1941. Cloth. Price $7.50. Pp. 521, with 50 illustrations and 3 color plates. St. Louis: The C. V. Mosby Company, 1941.

This book represents the most thorough and complete report on the subject that has yet appeared in print. The toxemias of pregnancy remain the most important of the many unsolved mysteries of obstetrics and, in many parts of the country, today constitute the most frequent cause of maternal death. Dr. Dieckmann, with amazing thoroughness, has incorporated in his book all the known facts and the more probable theories concerning etiology, diagnosis and treatment. His selection of material and the judicial presentation is beyond criticism.

In his preface the author states that his objective in writing the book was to acquaint the obstetrician and the investigator, untrained in obstetrics, with some of the physiology and pathology of obstetrics. This objective he has attained in full measure. To it the reviewer would like to add that every prac-

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titioner of obstetrics, either as a specialty or as a part of general medicine, will profit greatly by careful study of the book. All of us interested in the subject owe Dr. Dieckmann a debt of gratitude for the obviously enormous labor he has expended in its preparation. J. W. H.

The Medical Clinics of North America. Military Medicine, Index Number. Volume 25, Number 6. Cloth. Price $16 per clinic year. Pp. 422, with 50 illustrations. Philadelphia: W. B. Saunders Company, November 1941.

The articles are well chosen and contributed by men who are authorities in the various fields selected. The following subject matter appears in this series of papers.

"The Physician in Selective Service and the Army." This deals with the organization of selective service, especially the role of the examining physician, and also touches upon some of the special physical requirements in certain branches such as aviation, submarine, deep-sea diving, etc.

Another article deals with the medical organization in permanent camps and also in the field. Most of this will be worth-while information to physicians who are about to enter the military service. The medical service with combat units is described and illustrated. Hospitalization behind the front is described, including hospital centers and general hospitals. An excellent article on tuberculosis in military medicine is included. Likewise, communicable diseases in military medicine. Past experiences, particularly those of World War I, are brought to the attention of the reader and the very practical problems incidental to mobilization are referred to with some detail such as, measles, common cold, mumps, gastro-intestinal diseases, pneumonia, meningococci meningitis, diphtheria, etc.

Cardiovascular disease as a military problem is included.

Likewise, military ophthalmology is timely, particularly as it contains reference to lacrimating war gases; also, the effects of altitude on ocular function and war injuries involving the eye.

Another article concerns the war injuries of the ear, nose and throat.

An article on military dermatology and syphilology contains some practical information on the vesicant war gases, burns, etc. Another, deals with nutritional problems in the military forces. This includes some practical suggestions on planning an adequate diet and touches upon vitamins.

The article on psychiatric aspects of military medicine is perhaps the most practical and immediately useful to the average physician entering military service.

The article on x-ray examinations of the chest deals primarily with pulmonary tuberculosis. Perhaps a more timely subject would be the use of x-ray to discover and locate foreign bodies.

"Chemotherapy of Acute Infections" and the use of sulfanilamide and its derivatives are discussed.

(Continued on page 352)

APRIL
27
28
29

Circle
The Dates

and

plan to attend

the Annual

Spring
Postgraduate
Clinics

Chippewa Falls April 27
Hotel Northern

Wausau April 28
Hotel Wausau

Fond du Lac April 29
Hotel Retlaw

Turn To . . .

page 326 for
complete details

The article on shock and treatment of burns is timely but insufficient in view of our present national situation. The same would apply to the article dealing with the treatment of minor war injuries.

It is quite obvious that the various subjects were selected prior to December 7, 1941. Since this volume is merely a collection of unrelated papers one finds what is inescapable; namely, disproportionate emphasis, particularly having in mind the course of events since these articles were collected.

The book will give the inexperienced physician some worth-while information, most of which however is a reflection of experiences in World War I. The non-military experienced physician will be impressed by the range of medical problems that confront the physician serving with our armed forces. In short, he will realize that in becoming a medical officer in the army or navy his services will be almost entirely that of a physician. It will be his job to see that men are fit for service, or kept well and made well, if possible, and that the soldier, although in excellent physical condition is subject to all the diseases commonly found in civilian life with the added incidence of physical injury.

The fault with a collection of papers such as makes up this book is the difficulty of emphasizing and throwing into the foreground the most practical and urgent problems that confront a physician who is actually serving in the army or navy. In short, this book is not unlike other efforts more or less peculiar to the allies of being "too late and too little." Supplementary papers are now much needed. Perhaps the offices of the Surgeons General of the Army and of the Navy could publish a quarterly, either combined or separately, dealing with contributions from the physicians now actively engaged behind the lines and at the front, and also whatever information can be had from the experience of our allies and enemies as well. Such a series would be very instructive and helpful. W. F. L.

Synopsis of Allergy: By Harry L. Alexander, A. B., M. D., professor of clinical medicine, Washington University School of Medicine, St. Louis; editor of The Journal of Allergy. Cloth. Price $3. Pp. 246, with 22 illustrations. St. Louis: The C. V. Mosby Company, 1941.

This book is a synopsis of present day concepts of allergy in a convenient pocket size edition. It includes all the recognized forms of allergy with regard to diagnosis and treatment, and should be of considerable value to student and practitioner alike. Its practical value consists of concise statements, outlines of treatment, tables showing differential diagnostic points, and information regarding preparation of extracts and standardization of materials for treatment of various forms of allergy. H. P. D.

Arthritis in Modern Practice: The Diagnosis and Management of Rheumatic and Allied Conditions. By Otto Steinbrocker, B. S., M. D., assistant attending physician and chief, Arthritis Clinic, Bellevue Hospital, Fourth Medical Division, New York City. With chapters on Painful Feet, Posture and Exercises, Splints and Supports, Manipulative Treatment and Operations and Surgical Procedures by John G. Kuhns, A. B., M. D., F. A. C. S., chief of the Orthopedic and Surgical Service, Robert Breck Brigham Hospital; assistant visiting orthopedic surgeon, Boston Children's Hospital. Cloth. Price $8. Pp. 606, with 321 illustrations. Philadelphia: W. B. Saunders Company, 1941.

This book was written for the practitioner of medicine as a useful and practical source of information relating to rheumatic disease. It presents the essentials of diagnosis and treatment concisely and clearly. Throughout, the authors have minimized the discussions of theoretical matters and have but briefly described the pathology, laboratory details and the like. Always, the experience of the authors makes itself felt, and this is commendable.

The first chapter, a very important one, deals with the incidence, medicosocial and economic aspects of arthritis. Subsequent chapters deal with the various types of arthritis. There are also chapters on fibrositis, backache, sciatica, physical therapy, local and regional analgesic methods, painful feet, laboratory procedures of diagnostic value, posture and exercises, splints and supports, surgical procedures and an excellent glossary. Chapter XVI, on pain in diagnosis and treatment, is one of the best and one wonders why it is not Chapter II rather than XVI in the book's arrangement. A separate chapter on spondylitis is questionably justifiable since it does not simplify classification of rheumatoid and osteoarthritis and makes for considerable needless repetition in the discussion of etiology, symptomatology, therapy, etc. Inclusion of the subject in the respective chapters on rheumatoid and osteoarthritis would appear to be more satisfactory since the fundamental aspects are essentially the same. The separate chapter on painful shoulder might also, perhaps, be criticized, on a similar basis. The statement on page 166 that gout is of course not a fatal disease might be tempered since the disease is a general metabolic disturbance which may be fatal because of renal (gouty nephritis) and cardiovascular involvement.

The book is well written. The illustrations, which are numerous, are simply superb. This is a well bound, well constructed, attractive volume. The authors and publishers can be commended. The physician will find this to be a practical and very useful addition to his library. O. O. M.

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The 1941 Year Book of Pathology and Immunology: Edited by Howard T. Karsner, M. D., professor of pathology, director of the Institute of Pathology, Western Reserve University, Cleveland; and Sanford B. Hooker, A. M., M. D., professor of immunology, Boston University School of Medicine; member, Evans Memorial for Clinical Research and Preventive Medicine; immunologist, Massachusetts Memorial Hospitals. Cloth. Price $3. Pp. 623, with 136 illustrations. Chicago: The Year Book Publishers, Inc., 1941.

This book is edited by the same authors and follows the plans of the initial "Year Book in Pathology and Immunology" accorded such an appreciative welcome last year. It again reviews and condenses a considerable mass of new material in these two basic sciences; in its index over 800 authors are listed. In addition to the abstracts, summaries and editorial comment on the publications of these authors, several original contributions on pertinent subjects have been included, notably on the Rh factor in clinical and legal medicine by Wiener, its significance in erythroblastosis foetalis by Levine, and on the pathology of shock by Virgil Moon. The aim defined last year of attempting to bridge the gaps between the pathological laboratory and clinical practise, and between the immunologist and the general practitioner or public health worker is still apparent. A surprising number of clinical diagnostic procedures and studies are interspersed among the experimental data. There are brief sections on new laboratory methods and technics. M. B.

Essentials of Endocrinology. By Arthur Grollman, Ph. D., M. D., associate professor of pharmacology and experimental therapeutics in the medical school of the Johns Hopkins University; formerly, associate professor of physiology and instructor in chemistry in the same institution. Cloth. Price $6. Pp. 480, with 74 illustrations. Philadelphia: J. B. Lippincott Company, 1941.

This volume provides a helpful summary of clinical endocrinology for practicing members of the medical profession who are anxious to handle routine endocrine cases intelligently. It does not attempt to give a detailed background of biology and chemistry, and in that sense, the book can hardly be considered as an exhaustive monograph on endocrinology.

The structure of the book is the classical medical textbook form with sections on symptomatology, pathology, differential diagnosis and treatment for each endocrine disease discussed. For each gland, there is a brief summary of physiological, anatomical and chemical considerations, well illustrated with photographs, microphotographs and chemical formulas. The book opens with a short chapter on the history of endocrinology and ends with a resume of the chemistry of the steroid compounds. The style is satisfactory and the material is clearly presented. The publishers have done a splendid job in the actual preparation of the volume.

It is perhaps regrettable that a good many newer concepts and recent works which were available even

(Continued on page 354)

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BOOK REVIEWS—Continued

at the time the manuscript was being prepared are not included. For example, much of the recent helpful material on the endocrine function of iodine and its relation to proteins and thyroid activity is omitted. Similarly, the pancreatic-hypophyseal, adrenal cortical relationships are only mentioned. These are matters which are of more than passing interest to clinical endocrinologists, since their practical importance is already beginning to be felt.

These criticism, however, are of a general sort and may be directed toward any textbook in a rapidly changing field. Certainly in endocrinology, one may anticipate that any volume will be out of date before it is off the press. Subsequent editions of this book should help to remedy some of these omissions. E. S. G.

Treatment of the Patient Past Fifty: By Ernest P. Boas, M. D., assistant clinical professor of medicine, Columbia University College of Physicians and Surgeons; associate physician, Mount Sinai Hospital, New York City; chairman, Committee on Chronic Illness, Welfare Council of New York City. Cloth. Price $4. Pp. 324, with 19 illustrations. Chicago: The Year Book Publishers, Inc., 1941.

This book presents a systematic approach to the elderly patient, which is logical, practical, and emphasizes the importance of the patient rather than the disease. To quote "with the aged above all the physician must keep in mind that he is treating primarily a human being reacting to the stresses of living, not a disease."

It is a book well worth reading and can be recommended for its frequent therapeutic suggestions which reflect the author's experience in treatment of patients as well as the pathologic or aging processes. J. B. B.

Immunology: By Noble Pierce Sherwood, Ph. D., M. D., F. A. C. P., professor of bacteriology, University of Kansas, and pathologist to the Lawrence Memorial Hospital, Lawrence, Kansas. Ed. 2. Cloth. Price $6.50. Pp. 639, with 27 illustrations and 7 color plates. St. Louis: The C. V. Mosby Company, 1941.

The second edition of this textbook has been brought up to date and thoroughly revised by the author. The revision has resulted in a more logical grouping of the subject matter. However, the author at times still allows himself to ramble away from the subject under discussion, one example being the brief mention of blood banks in the chapter on toxins and antitoxins. A bibliography is given at the end of each chapter. This is usually adequate although one glaring omission is the failure to mention the work of Kendrick on pertussis vaccines. After reading the book one has the impression that many of the subjects are discussed too briefly and superficially by the author. On the whole, this book would be adequate only for beginning students, and it should be supplemented by considerable required reading. E. A. B.

The Blood Bank and the Technique and Therapeutics of Transfusions: By Robert A. Kilduffe, A. B., A. M., M. D., F. A. S. C. P., director, laboratories, Atlantic City Hospital; city bacteriologist, Atlantic City; serologist, Municipal Hospital for Contagious Diseases, Atlantic City; pathologist, Atlantic County Hospital for Tuberculous Diseases; serologist, Betty Bacharach Home for Crippled Children; serologist, Jewish Seaside Home, Atlantic City, etc.; formerly, Major, Medical Corps, United States Army; and Michael DeBakey, B. S., M. D., M. S., F. A. C. S., assistant professor of surgery, School of Medicine, Tulane University of Louisiana; visiting surgeon, Charity Hospital, Touro Infirmary, and Mercy Hospital, New Orleans; associate in surgery, The Ochsner Clinic, New Orleans. Cloth. Price $7.50. Pp. 558, with 214 illustrations and 1 color plate. St. Louis: The C. V. Mosby Company, 1942.

The transfusion of whole blood or plasma is a simple and common procedure. Its protection from contamination involves a meticulous technic which requires the strictest attention to the minutest detail. Any break in this technic, any neglect of the smallest detail from the cleaning and preparation of glassware and rubber tubing to proper grouping of the blood, and the preservation of both plasma and blood will result in serious hazards for the patient. With an increase in knowledge concerning the use of both whole blood and plasma, they have become essential therapeutic agents. It is timely, therefore, for the publication of a compend on the subject. This book is a compilation and collation of the large amount of literature on blood and plasma transfusion.

The first chapter gives a historical account of the development of blood transfusion from the period of mythology to the present. This is followed by sixteen chapters each dealing in a practical way with the methods used to transfer blood or plasma from one person to another. Probably the chapter, "The Operation of a Blood Bank," is of the most interest currently.

The author's caution against small hospitals attempting to operate a blood bank unless there is a full-time pathologist directing the laboratories and

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unless an adequate staff of trained technicians is employed. In this connection they say that a blood bank should not be considered feasible for hospitals of less than 350 to 400 beds. The selection of refrigerating equipment is described and emphasis is placed on the necessity of maintaining a constant temperature at about 4 C.

One of the most important and serviceable features of the book is the description of methods for the cleaning and sterilizing of glassware and rubber tubing. Here the smallest detail is emphasized. It is regretted that the authors did not in this section of the book emphasize the importance of preventing pyrogen contamination. The chapter on blood banking would seem to be the proper place for the description of methods by which pyrogen-free distilled water can be prepared. It also seems that in this chapter the preparation of anticoagulants and other fluids used in the bank should have been described. However, it is briefly referred to in another chapter.

The chapter on blood grouping and crossmatching details the common methods used for this purpose. Special attention is given to the subgroups of group A and group AB blood, and sources of error resulting from some atypical agglutinins is well presented. However, no mention is made of some of the recently recognized antigenic factors which have been shown to cause transfusion reactions. This proves not to be a serious omission since later in the chapter on "Complications of Blood Transfusion" these factors are discussed.

The book is timely, well published and will be found to be helpful to those contemplating the organization of a blood or plasma bank. After each chapter there is an extensive bibliography which adds greatly to the value of the book. It is not a book alone for the laboratory director and technicians but contains much of interest to surgeons and general practitioners. This is especially true of the chapter on "Rationale, Indications and Contraindications" and the chapter on "Complications of Blood Transfusion."

The authors distinctly favor the use of blood within a week or ten days after it is collected. The importance of transfusing stored blood without first raising it to body temperature is not sufficiently emphasized. W. D. S.

The March of Medicine. Number VI of the New York Academy of Medicine Lectures to the Laity, 1941. Cloth. Price $2. Pp. 154. New York: Columbia University Press, 1941.

The purpose of these lectures to the laity at the New York Academy of Medicine is explained as being two-fold, first to show historically how medicine has developed, and second, to reveal its social and cultural significance. The essays in this edition make a noteworthy contribution toward these objectives. Contrary to the two previous editions, in which all the lectures were delivered by Doctors of Medicine, two of the six in this group were given by Doctors of Philosophy. While obviously no special knowledge of medicine nor a scientific vocabulary is

(Continued on page 356)

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a prerequisite for an understanding of these lectures, they may well be a source of stimulating and profitable reading especially for the more philosophical physician. M. L. C.

Surgical Practice of the Lahey Clinic, Boston, Massachusetts. Cloth. Price $10. Pp. 897, with 376 illustrations. Philadelphia: W. B. Saunders Company, 1941.

This volume is a collection of recent papers by the members of the Lahey Clinic staff. It consists of symposia on the thyroid gland; esophagus and lungs; the breast; stomach, duodenum, and small intestine; the biliary tract; the colon, sigmoid, and rectum; the pelvis; the kidney and prostate gland; the bones and joints; the brain, spinal cord, and nerves; and anesthesia. There is no doubt that this is a worth-while collection of surgical procedures which every surgeon should review, whether he agrees with them in principle or not. It offers an excellent opportunity for the surgeon in practice, who does not have access to the current literature, to find this material in one volume. This book is very worth while and is heartily recommended. K. E. L.

A Hand-Book of Ocular Therapeutics: By Sanford R. Gifford, M. A., M. D., F. A. C. S., professor of ophthalmology, Northwestern University Medical School, Chicago; attending ophthalmologist, Passavant Hospital, Wesley Memorial Hospital, Cook County Hospital. Ed. 3, thoroughly revised. Cloth. Price $4. Pp. 410, illustrated with 69 engravings. Philadelphia: Lea & Febiger, 1942.

In presenting the third edition of "Ocular Therapeutics," Dr. Gifford brings up-to-date the proven therapeutic agents and methods in the field of ophthalmology. This well-written book of 410 pages contains an abundance of information in a most available state.

The author takes up first, equipment and drugs in general, and then discusses the diseases of the eye with greatest emphasis on the most successful manner of treatment. Especially noteworthy among the newer therapeutic agents discussed are the vitamins, the sulfonamide drugs, and the sympatho-mimetic and parasympatho-mimetic drugs. No less interestingly described are the long proven drugs and methods of treatment.

As in his other works, the author reveals himself as an ardent student and conscientious practitioner of ophthalmology. Ocular therapeutics is a valuable and necessary help toward a higher quality of medical practice. P. A. D.

Heart Diseases: A Handbook for Students and Practitioners: By Marion Ellsworth Anderson, A. B., M. D., Clinton, Iowa. Cloth. Price $1. Pp. 110, with 9 illustrations. Clinton, Iowa: Allen Printing Company, 1941.

This little book is obviously not meant as a textbook of diseases of the heart. It may well be termed a fireside chat on the field of heart ailments by a general practitioner. It is a good example of the application of the basic principles of inspection, palpation, percussion and auscultation when only a minimum of laboratory means is available. The

author includes a chapter on hunchback which is quite interesting. The therapy which is briefly outlined is sound and the explanation for the usage of these drugs is adequate. This book is worth-while reading. H. H. S.

A Manual of Pharmacology and Its Applications to Therapeutics and Toxicology. By Torald Sollmann, M. D., professor of pharmacology and materia medica in the School of Medicine of Western Reserve University, Cleveland. Sixth edition, entirely reset. Cloth. Price $8.75. Pp. 1,298. Philadelphia: W. B. Saunders Company, 1942.

This, the sixth edition, contains some newly written sections introduced through the sacrifice of certain better written parts of the previous edition. It continues the encyclopedic characteristics of previous editions which make it of value especially to the professional pharmacologist. However, for medical students and practicing physicians, certain other well-known texts may be expected to continue to be generally preferred. A. L. T.

Surgery of the Ambulatory Patient. By L. Kraeer Ferguson, A. B., M. D., F. A. C. S., Lieut. Commander, Medical Corps, United States Naval Reserve; assistant professor of surgery, University of Pennsylvania School of Medicine; assistant surgeon, Hospital of the University of Pennsylvania; surgeon, Philadelphia General Hospital and Doctors Hospital; consulting surgeon, Frankford Hospital; chief of the Surgical Out-Patient Department, Hospital of the University of Pennsylvania; chief of the Proctologic Clinic, Hospital of the University of Pennsylvania and Philadelphia General Hospital. With a Section on Fractures by Louis Kaplan, A. B., M. D., F. A. C. S., associate in surgery, University of Pennsylvania School of Medicine; associate in surgery, Mt. Sinai Hospital; in charge of the Fracture Division of the Surgical Out-Patient Department, Hospital of the University of Pennsylvania. Cloth. Price $10. Pp. 923, with 645 illustrations. Philadelphia: J. B. Lippincott Company, 1942.

This book has a total of 923 pages, and has for its object a presentation of surgical procedures that may be practiced in one's own office. It is divided into three parts, the first of which deals with a discussion of typical lesions with a description of their cause, course and care; the second part with common surgical lesions of specific parts, and methods of treatment; and the third with fractures and dislocations and their treatment in ambulatory patients. It is well illustrated throughout with drawings and photographs. This book covers the field of minor surgical procedures in an excellent manner, and will prove to be a valuable addition to a well rounded surgical library. To the surgeon without experience in general practice, it may be criticized as advocating certain procedures that might better be undertaken in a hospital. However, to the general practitioner who daily performs just such surgery on the ambulatory patient, this book will be most welcome. The extent to which local anesthesia can be applied is emphasized and adequately presented in the chapter on anesthesia. The author

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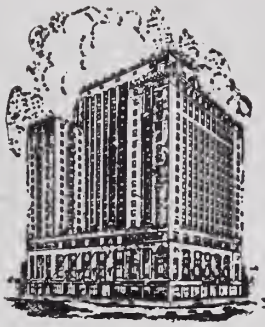

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recommends vinethene (di-vinyl ether) as the anesthetic of choice if a general anesthetic must be used, because of its attributes of rapid induction and quick recovery. This book should find particular favor with the medical student, and might be designated as the first book to acquire for his surgical library. It is certain to find wide favor among general practitioners. D. W. M.

Communicable Disease Nursing. By Theresa I. Lynch, R. N., Ed. D., instructor in education, New York University. Formerly superintendent of nurses and director of instruction the Willard Parker Hospital, New York City. Cloth. Price $3.75. Pp. 678, with 156 illustrations and 5 color plates. St. Louis: The C. V. Mosby Company, 1942.

Even the briefest scrutiny of this nurse-educator's first edition convinces the reader that it is a book written by one with experience in various phases of community health. It is designed for distinctly practical purposes.

The content includes the diseases suggested for study in the "1937 Curriculum Guide for Schools of Nursing." Many of the 156 expressive illustrations are photographs taken in various institutions by Anna M. Goodrich. Among these are: Henry Street V. N. A. Service, Presbyterian University Hospital School of Nursing and Willard Parker Hospital in New York City; Yale University School of Nursing, New Haven, Conn.; Jersey City Medical Center, Jersey City, N. J.; Kingston Avenue Communicable Disease Hospital, and Brooklyn School for Home Making, Brooklyn, N. Y.

The medical aspect of forty-five communicable diseases is skillfully telescoped to include only the most basic material; thus, classroom lectures and discussions, plus current literature, can be employed to supplement the particular teaching program. But, the real value of the book is in the author's presentation of the technical aspects of communicable disease nursing. With exceptional photographs as visual aids, Miss Lynch, with extraordinary zeal, acquaints one with home practice and problems. She almost glorifies the ofttime resented hand scrub and gowning procedures. And while she states that technics are not advanced as perfect—for universal application—she at least does not by-pass any, such as the perplexing problems of disinfecting flashlights, stethoscopes and sphygmomanometers. With refreshing frankness she uses illustrated hospital or home situations to show the application of technic. Moreover, she does not fail to include such procedures as transferring patients from one ward to another, or to discuss visiting problems.

This book is designed primarily for student-instructor use. However, because the content is so graphically substantial and candidly presented, it should be enthusiastically received in expanding defense areas, where problems of communicable disease control are being aggravated. Also, it should give unlimited support to those who are active in the instruction of the care of communicable disease in the home. G. C.

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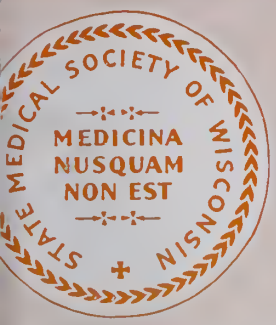

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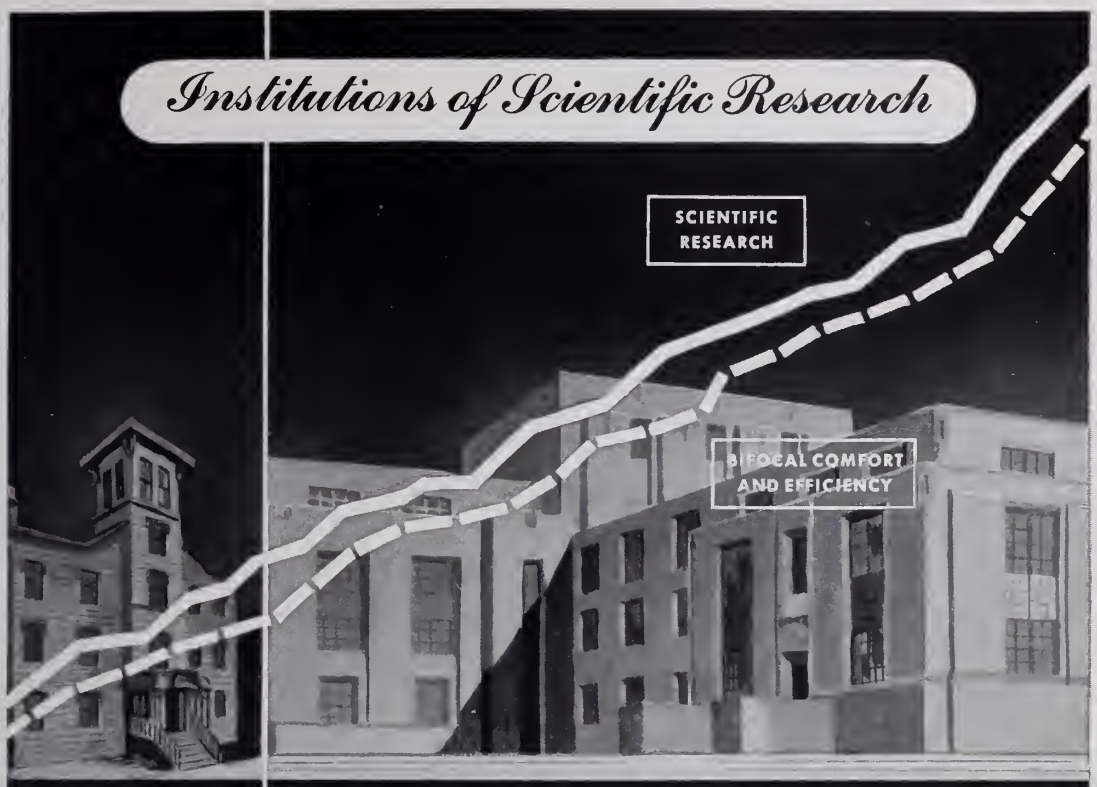

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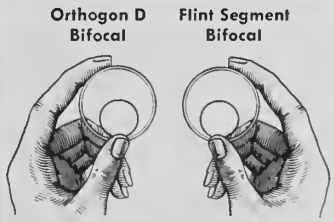

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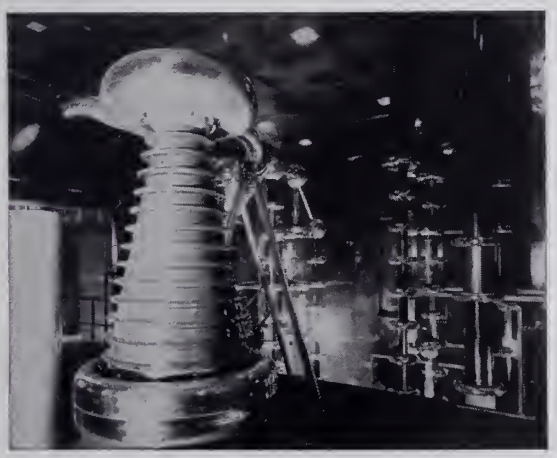

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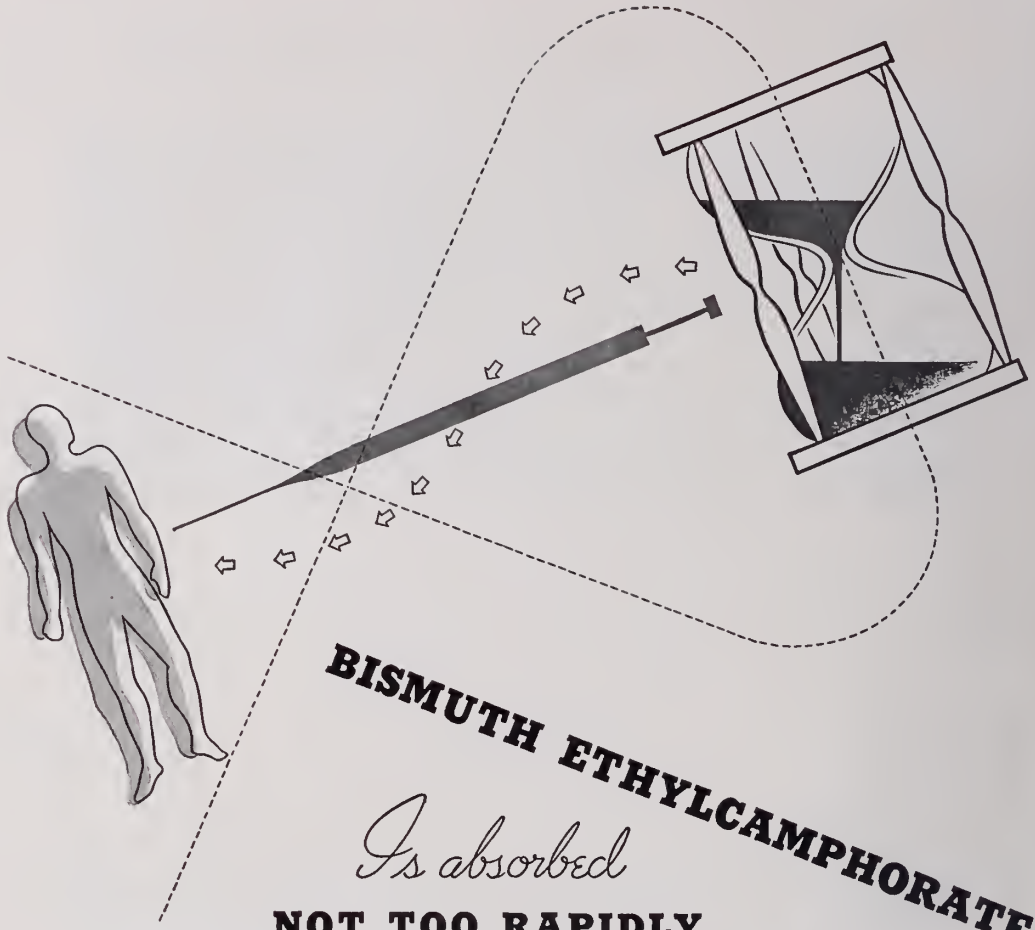

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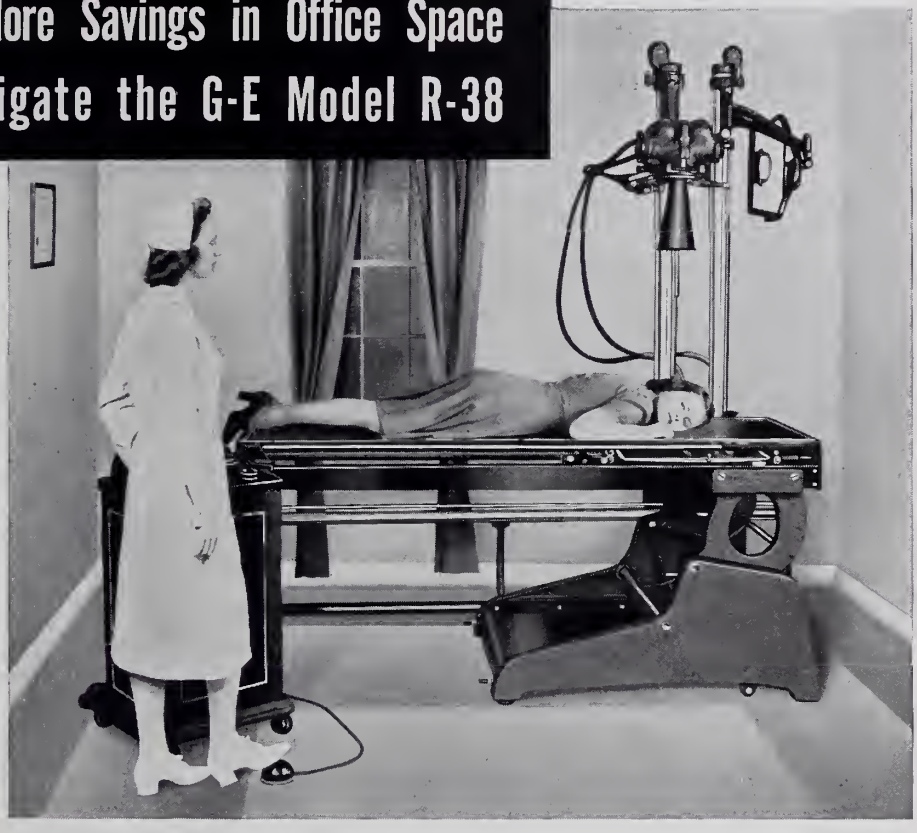

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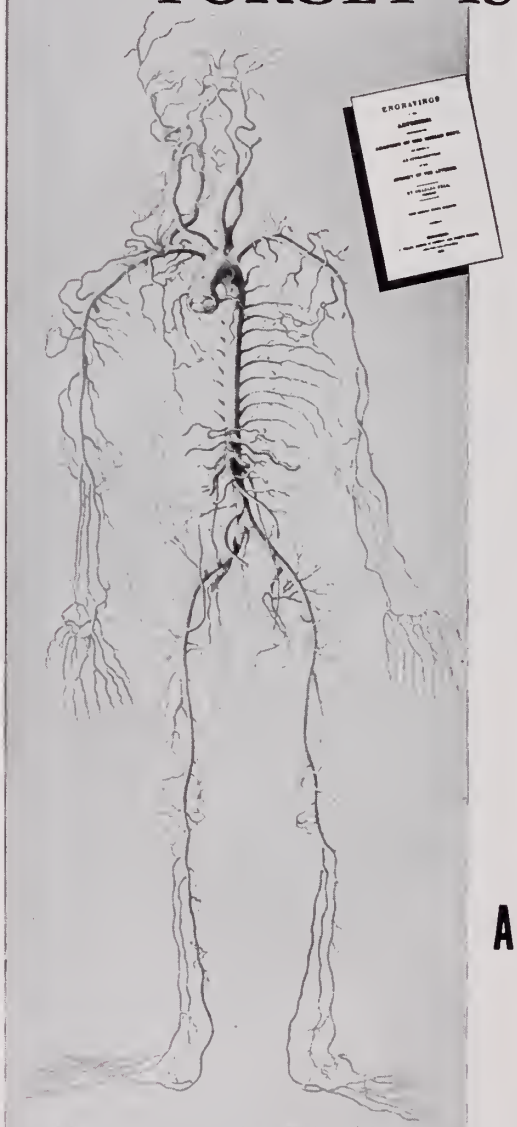

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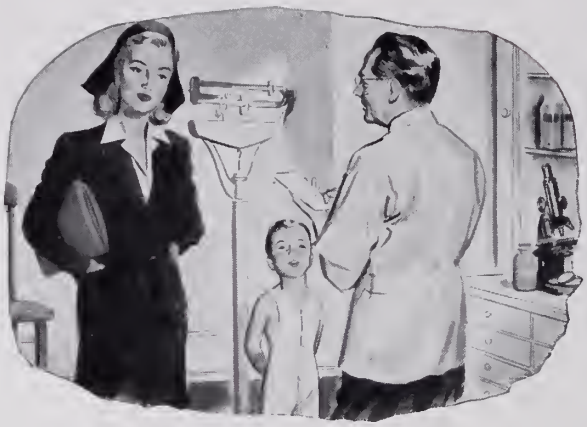

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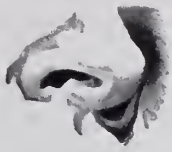

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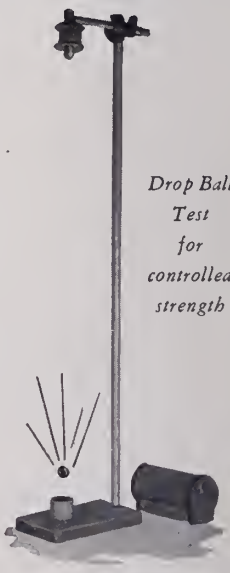

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THE WISCONSIN MEDICAL JOURNAL

VOLUME 41, NO. 5 Copyright, 1942, by The State Medical Society of Wisconsin MAY, 1942

Late Neurologic Complications of Injury to the Nervous System*

By HENRY W. WOLTMAN, M. D.**
Rochester, Minnesota

INJURY to the nervous system may leave in its wake residual effects of prolonged or permanent duration, or it may engender a completely new array of complications which, by their nature and gravity, may overrun those of the original disaster. If it is true that the spinal fluid of half of all newborn infants contains free blood, then the act of being born is one of the most dangerous experiences of a lifetime. Even cesarean section does not assure safe delivery into this world.[2] But, where is the line that divides what we shall call an "injury" from that which we shall call "no injury"?

INJURY TO THE BRAIN

General Considerations

To our medical forebears of a hundred years ago, fracture of the skull was not the arresting problem it is today. Among animals, modern man stands alone in being subject to fracture of the base of the skull,[1] and the high incidence of this lesion is due to his technical advances in transportation. The great American sport is not bullfighting but the raw passion of murder of our unsuspecting neighbors and their children on the highways. The great teacher, Sylvius, accused a young upstart called Vesalius of irreverence for teaching that woman has as many ribs as man. We are tempted to agree with the parting shot of Sylvius, "Yes, man has changed, but not for the better." In 1940, the score stood: killed, 35,000; wounded, 1,400,000.

Estimates of the number of persons who carry away permanent residual effects vary widely. There are difficulties in drawing up statistics and difficulties in understanding the statistics drawn up, so I shall cite none; but it is safe to say that considerably more than half of the major craniocerebral injuries are caused by the automobile, and that the next most frequent causes are falls on the head and blows to the head.[1, 3, 4, 5, 6, 17]

Types of Damage to Brain

The pathologic changes that occur in cases of fatal outcome have been studied carefully. The architecture and elasticity of the skull have an important relationship to what happens not only to the skull, but also to its contents when the cranium is subjected to violent injury. Damage to the brain generally is greatest at the site of impact, but it may be even greater at the opposite pole. Wide areas along the base also are contused. Large and small hemorrhages are especially common in the white matter adjacent to the ventricles and in the brain stem. Damaging effects are added by anoxemia, edema and fat embolism when there have been fractures or burns. Local regions of cell injury and demyelinization are found. Glial elements spring into activity and contract. The most characteristic late defects are scars situated at the summits of the convolutions.[12]

Neurologists knew but did not appreciate the fact that various parts of the brain of different density are affected unequally by the acceleration and deceleration of physical violence.[8, 25] Kinetic energy varies with the mass and the square of the velocity, as Danson has pointed out, not only of the moving automobile but also of the moving brain.

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* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

** From the Section on Neurology, The Mayo Clinic.

Thus, it may be seen that the range of organic changes passes by imperceptible degrees from mild and transitory distortion at one end to gross laceration and its attendant evils at the other. This is reflected in the clinical picture. Neurologists now understand better such phenomena as concussion, which, be it noted, is a clinical and not a pathologic designation, and also understand why an appraisal of the organic situation may collide with the interpretation of any functional aspects that may exist independently or be superimposed on the organic situation. Neurologists can understand also that already existent arteriosclerosis or alcoholism may interfere with restitution.

While these observations are still fresh in mind, and to emphasize the fact that organic and functional disturbances frequently coexist, let me dwell on the latter a moment. As Symonds remarked pointedly, "It is not only the kind of injury that matters, but the kind of head."[29] What is required is a psychobiologic and psychopathologic appraisal of the patient or, in short, a full answer to the question, "What sort of person was he before he was hurt, and what about his environment and his responses to it?" After the confusion caused by the injury dies down, fears and wishes in the minds of patient and relatives take root, the solicitude of friends furnishes the soil, and legal talent the vitamins. In this milieu the symptoms of organic disorder, if there were any, subside, while those of a functional nature put in their appearance.

Symptoms

The telltale symptoms of hysteria, which is the unconscious conversion of emotion into physical disability, or of malingering, which is the conscious act of deception for purposes of gain, are marked by their inconsistency. The patient is often surly and resentful of any probing into the details of his difficulties; he may groan and put forth a show of disability, fail to follow the examiner's receding hand with the supposedly weak extremity (although the power to do so is there) when strength is tested, acquire and discard anesthesias on suggestion, and then blithely button up his collar with an allegedly anesthetic hand.

The presence or absence of fracture of the skull is not of much value in assessment of the probable degree of subsequent disability. It is generally agreed that older patients do less well than younger ones, and that the age of the patient is the most important single factor in estimation of the prospects of recovery. There is no evidence that early resumption of work is harmful, provided no severe symptoms are present. Indeed, on the basis of the most complete follow-up studies, the ordering of a long period of rest without preliminary appraisal is an example of failure in the art of medicine.[27,34] It should be emphasized, however, that a great and arbitrary divergence of opinion exists with regard to the advisability of prolonged rest in bed. Russell[26] learned from workers who had been injured that eighteen months after the time of injury 30 per cent of those receiving compensation still reported themselves unfit for unrestricted work, whereas only 9 per cent of those receiving no compensation reported themselves as unfit for unrestricted work. It is emphatically stated by some that a lump-sum settlement will cause the symptoms of psychoneurosis to disappear, but it is said with equal emphasis by others that such a maneuver is useless. This latter experience seems to me to be the more common.

Russell also offered some sound advice when he wrote that it should be made clear to the patient that he does not automatically lose any subsequent claim he may make for compensation if he returns to unrestricted work, and that it is inadvisable for him to relinquish all claim to compensation because of the small danger of epilepsy after a severe head injury.

Headache, giddiness, nervousness, insomnia and what is loosely referred to as "loss of memory" often are regarded as being of neurotic origin, but the regularity with which they appear makes this unlikely. Headache, which Russell noted among 42 per cent of his patients, was more common among young persons than among older ones and was more common among those in whom the period of unconsciousness had been less than twenty-four hours. Dizziness, on the other hand, was more often complained of

by the older patients. It is easier to assess the validity of a patient's complaint when there is some objective sign to substantiate it. When a patient who complains of vertigo when he attempts to carry out the offices of his work sits quietly on the examining table, nystagmus frequently is not found. Often, however, nystagmus, accompanied by vertigo, can be provoked by having the patient recline quickly on the table. Results of caloric tests also provide information but the performance and interpretation of the results of such tests must be left to the expert. Headache and giddiness may last for years, and the treatment is not satisfactory. Results of the insufflation of air by the spinal route have been disappointing. Elevation of the patient's head at night, restriction of the intake of fluids, and the administration of potassium iodide may be tried. Usually, no harm can be done by the physician's encouraging the patient to do light work.

Helpful information can be obtained by asking the patient what he himself can recall of the accident. Thus, a quarryman who says that he is well except for inability to use his right arm and leg may recall having carried his lunch pail to the place in the quarry in which the men assembled to eat their meals. He was told later, but cannot remember it himself, that the blast had occurred at 3 o'clock in the afternoon and that a rock had hit him on the head. The next thing he can recall is that a nurse was bathing him a week later, while he was in a hospital. Now let us see what that "fussy" woman who complains of so many things has to say. Yes, she can recall exactly what had happened. She was sitting near the front of a street car when it stopped suddenly and a suitcase fell from the rack above her. It struck her on the top of her head where it now hurts. She lost consciousness at once, had to be carried to a drug store, and a few hours later, when she regained her senses, was aware of the pain which has been there ever since. The retrograde amnesia exhibited by the first patient is characteristic of true concussion. This may be followed by a period of excitement and this in turn by a period of confusion.

Complications

The prognosis for recovery from these states of aberration is good, even though they may last many weeks. After this there may follow, although rarely, an organic type of dementia that may be permanent. Disorders of behavior are more common, more serious and more lasting among children than among others. Mental pictures which resemble those of schizophrenia, paranoia and manic-depressive psychosis may ensue. Occasionally, a patient who has had previous attacks of manic-depressive psychosis may suffer recurrence of such attacks immediately after an accident. Older physicians have told of patients whose psychosis was cured by a blow on the head. At the time we listened politely, but in the light of the results obtained by the newer methods of shock therapy, we now have reason to think they were right.

Often some focal portion of the brain bears the brunt of the injury. This is especially likely to happen when open, or penetrating, injuries are sustained. Paralysis, hemianopsia, aphasia and a long train of disturbances recognized as having an organic cerebral origin may result. Tremor and parkinsonism may appear before the patient has regained full consciousness. Involvement of the vegetative apparatus may occur. These include diabetes insipidus,[26] diabetes mellitus (which may be refractive to treatment with insulin),[1] obesity, testicular atrophy[28] and impotence, peptic ulcer,[33] paroxysmal hypertension, fever, and tachycardia[24] and narcolepsy.[7]

One of the symptoms most feared is epilepsy. It may appear many years after the time of injury. There is great discrepancy in statements made as to the likelihood of epilepsy following injury to the brain. I previously made the statement that the line between injury and no injury is like that now existent between the two hemispheres. This is readily understood, since 35 per cent of normal persons report having sustained some injury to the head.[21] More harm than good is done in such instances by frightening the patient with things that may never come to pass, and this may justify acceptance by the physician of one of the lower

figures quoted; that is, that epilepsy follows injury to the brain in "less than 2 per cent" of cases.[28] There is much greater danger in the case of penetrating wounds of the head. In connection with gunshot wounds, the figure for the sequela of epilepsy appears to be in the neighborhood of 20 per cent.[35] This is startlingly close to the incidence of convulsions associated with tumors of the brain: 21.6 per cent.[20] Penfield gives the incidence of seizures after all supratentorial lesions as being 44 per cent.[23] The assumption that heredity is the explanation of the appearance of convulsions after injury to the brain must be proved.[35] Traction exerted by the scar on a blood vessel has been mentioned as an important part of the mechanism of causation,[11] and excision of the scar undoubtedly is helpful in some cases.[32] In war injuries of the head, suction, electrosurgical excision and removal of fragments reduce the mortality rate[15] and presumably lessen the possibility of epilepsy.

Encephalography may be of medical and legal assistance; however, care is needed in interpretation of the encephalograms. Thus, encephalograms made in the morning may be normal and those made in the afternoon may show what often is reported as being "cortical atrophy." Electro-encephalography, too, may be helpful, and is of assistance when the question of malingering arises.[16]

Any of the cranial nerves may be damaged permanently by injury to the head. The one most commonly injured is the eighth cranial nerve. Facial paralysis usually does not appear until a day or more after the accident. The nerve usually recovers spontaneously, but faulty regeneration of the nerve is common, and for this there is no satisfactory treatment. Loss of smell is not unusual. Most patients complain little of this; at least, we do not pay much attention to it if they do complain of it. It is interesting to note in what manner a patient may compensate for the loss of function of a special sense organ. I volunteered to a cook who had lost her sense of smell that now she probably cooked by sight. "No," she said, "I cook by ear and it works better and faster than did my nose." Sudden unilateral blindness with subsequent simple atrophy may follow blows, especially over the brow. This is an industrial accident more or less peculiar to members of the building trade.[9]

Cerebrospinal rhinorrhea may last many months and was a dreaded complication before the advent of chemotherapy. Now the dural defect may be repaired effectively. Pneumocephalus is, of course, the common accompaniment of a spinal fluid fistula.

Obstruction of the aqueduct of Sylvius or adhesions in the posterior fossa may lead to hydrocephalus, persistent or intermittent. Sometimes restriction of the intake of fluid and the administration of ammonium chloride may tide the patient over the critical period and allow time for the re-establishment of natural drainage. Meningitis or abscess of the brain may flare up years after the injury.

A not infrequent complication which must always be watched for is chronic subdural hematoma. Some weeks after an injury to the head, and it need not be a severe injury, recurrence or accentuation of the headache may be noted. This is often accompanied by an increase in intracranial pressure, although evidence of this is said to be less frequent among older persons than among younger ones. Gradually increasing hemiplegia and stupor may follow. A characteristic reptilian stare is rudely suggestive of the nature and seriousness of the condition. Be it noted that usually there is no fracture of the skull to guide the unsuspecting physician, and be it noted further that when the patient begins to decline he does so in a hurry, and within a few hours will be either dead or, if trephination is done promptly and this blood evacuated, cheerful and very much alive. Hemiplegia occurs often on the same side as that in which the clot is situated, and often there is a clot on both sides. Instead of blood there may be, rarely, a hydroma, which is a pocket of cerebrospinal fluid.

Injury to the larger vessels at the base of the brain may lead to the establishment of an arteriovenous fistula and this in turn to pulsating exophthalmos. Ligation of the carotid artery on the same side usually relieves the exophthalmos, but the physician must first make certain that the remaining

vessels will carry enough blood to assure an adequate supply to the brain.

Repeated injuries to the brain may lead to the appearance of spastic or dystonic disturbances which may remain stationary or progress, a condition referred to by members of the profession concerned as "punch-drunk."

It is not unlikely that the symptoms of multiple sclerosis (and this is possibly true of some other conditions such as dementia paralytica) may be accentuated by injury to the head. There appears to be no relationship to the development of glioma after injury,[21] but meningiomas have been noted to occur at the site of a previous blow.

The Spinal Cord

Injuries to the spinal cord usually are of the so-called closed variety. This is true even of war injuries, a high proportion of which are the result of fracture or fracture-dislocation. Open wounds, because of concomitant injuries of other structures, lead to a fatal outcome and are seen relatively seldom. The lesions that appear in the spinal cord are rarely sharply limited and are irregular in distribution and severity.[14] Direct mechanical trauma and hemorrhage as well as the impact of a missile may cause widespread dislodgment of the constituents of the fibers themselves and to these are added the effects of edema. In an injury to the spinal cord the physical effect is much like that which occurs when a glass is dropped on a stone pavement: the damage is instantaneous. It is for this reason that in such cases laminectomy usually offers little. Intelligent, sympathetic and tireless nursing care, on which I need not dwell, is of prime importance in the prevention of late effects which usually become such trying problems.

The most dangerous result of injury to the spinal cord is loss of the mechanism by which the bladder functions. In the first World War the death rate from infection of the urinary tract was appalling: about 80 per cent.[31] Repeated catheterization, nonintervention, massage through the abdominal wall, use of the indwelling catheter, and "prophylactic" cystotomy were resorted to. After severe injury to the spinal cord overflow and dribbling occur. When the lesion lies above the conus medullaris there develops, after an average of fifty-five days, involuntary reflex micturition. The ideal management of the incontinent bladder is undoubtedly that of tidal drainage, elaborated by Munro,[18] or one of its modifications.[19] By this method Munro was able to reduce the incidence of infection from 72 per cent to 14.2 per cent. The ideal, even though it may be attainable, is not always achieved or sought for. The administration of 5 to 7½ grains (0.3 to 0.47 Gm.) of a sulfonamide preparation, such as sulfathiazole, three times daily, is helpful. Transurethral resection of the internal vesical sphincter also may be useful.

Another complication of injury to the spinal cord with which physicians are faced is decubitus. Prevention is urgently indicated. This involves frequent changes in posture, distribution of pressure, and maintenance of the best possible circulation.[30] These measures apply also after decubitus has appeared. Circulation of the skin ceases when the pressure on it exceeds about 1 pound to the square inch (70 Gm. to the square centimeter).[10] Therefore, the weight of the patient should be distributed over as large an area as possible. This can be accomplished best by means of a water bed. Usually, a water bed is not available and a substitute is used, such as an air pillow, a continuous bath, a sheep's pelt, a pillow placed under the patient's knees, lumbar part of the spinal column and ankles, or a sawdust bed.[13] Instead of employment of numerous lotions, stimulants, astringents, coagulants, lights and radiation agents, Carty suggested that the edges of the wound be drawn together, and that the lesions be covered with two layers of elastoplast and forgotten about, until the dressing falls off or leaks. The performance is repeated, without washing, until the wound has healed.[5] At the clinic we have tried it in some cases and it has worked well. Not to be forgotten are provisions for the creation of interests, occupation and amusement for the unfortunate patient, for "nursing is an art which needs much practice."[22] Best possible use must be made of the muscles that remain and

in this respect the physical therapist and the orthopedist can be of much help.

After injury to the spinal column the patient may complain of pain along the distribution of a nerve root. If the paravertebral injection of alcohol is contemplated, it is advisable to precede this with a test injection of a local anesthetic agent, since the injection of alcohol may only make matters worse. The subarachnoid placement of absolute alcohol at a given nerve root must be regarded as a nice technical procedure, but it may give gratifying results. The exigencies of the case may require intraspinal section of the offending root.

A heavy blow on the spinal column sometimes leads to the development of adhesions between the arachnoid and the cord. This may result in gradually progressing paraplegia. A physician who had had this happen was well on the road to recovery after laminectomy before he could remember that he had injured his back. He then remembered that he had been trout fishing some months before, and had fallen from a cliff and injured his back, but in the same accident he had also broken his femur, which had provided the more pressing problem of dragging himself to some source of assistance.

After laminectomy in the cervical portion of the spinal column gradually progressive compression of the cord may appear, suggesting that a tumor, if the operation had been made for the purpose of removing one, was not removed completely. Lateral roentgenograms of the spinal column may disclose dislocation due to loss of support of the pedicles. Traction and support of the head usually cause the symptoms to leave within a few days.

The statement that protrusion of an intervertebral disk may result from injury, and that this in turn leads to backache and to sciatic neuritis, needs no amplification.

It is generally said that progressive muscular atrophy is not related to injury. In some instances, however, the onset of the atrophy shortly after injury and the fact that such atrophy begins at the site of trauma is so strongly suggestive that the idea of a relationship is almost inescapable.

The Peripheral Nerves

Of the late complications of injuries to the peripheral nerves, residual paralysis, neuromas and trophic ulcers need not detain us long. There are two conditions to which I should like to call your attention, since they are rather insidious in onset. The first of these is so-called tardy ulnar palsy, which may follow fracture of the elbow. The average age of such a patient who sustains a fracture is seven and a half years, whereas the average age of the patient at the onset of the ulnar palsy is about forty years. Obliteration of the ulnar groove results in raising of the nerve to an exposed position in which, without the patient's awareness, it becomes traumatized repeatedly. Transplantation of the nerve to a position of safety on the anterior aspect of the arm, if done early enough, arrests the progress of the disability and may result in a cure. Similar involvement of the nerve may occur in arthritis of the elbow, and for the same reason.

The other condition to which I referred is involvement of the median nerve at the wrist. Arthritis of this joint, because of the limited space between the bones and the anterior annular ligament, may compress the nerve. Trophic ulcers may appear on the index and middle fingers. Sensation and motility will be found to be impaired. Section of the annular ligament may lead to rapid subsidence of the neuritis and to healing of the ulcers.

In the field of injuries to nerves, too, medicolegal complications frequently arise. One patient allegedly had had a fragment of steel driven into his ulnar nerve. He was unable to move some of the muscles of his hand on request, but evinced good power in these muscles when other muscles of the hand were tested. There was not the slightest evidence of atrophy. He denied being able to detect touching of the ulnar part of the hand, but he could always tell that he could not feel it every time it was touched. Other physicians concurred in the diagnosis of malingering, but the nerve was explored eventually and found to be normal. "Surely in vain the net is spread in the sight of any bird."

In this sketchy review of the late effects of injury to the brain, spinal cord and peripheral nerves, I have dwelt on the more obvious, more common and better known complications. Of these, injuries to the brain are the most common and, barring transverse lesions of the spinal cord, are the most serious. The most important single cause is the savage abandon of the man behind the wheel.

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MONDAY, TUESDAY, AND WEDNESDAY

Mark on your calendar the dates of September 14, 15, and 16 for the One Hundred First Anniversary Meeting of the Society. Your attention is called particularly to the fact that the days this year are Monday, Tuesday, and Wednesday, instead of the customary Wednesday, Thursday, and Friday. The members of the Council on Scientific Work feel that this change will enable an even larger number of physicians to attend the meeting, due to the fact that their practices will be interrupted for a shorter period of time.

Cancer of the Urinary Bladder; Analysis of Fifty-One Cases*

By JOHN B. WEAR, M. D. and HOMER H. KOHLER, M. D.
Madison

A CLINICAL survey of tumors of the urinary bladder was presented before this Society five years ago. At that time it was stated that the more arresting term "cancer" should be used. The 51 case histories reviewed in the present survey contain diagnoses of cancer and represent all the tumors of the bladder seen at the State of Wisconsin General Hospital in the years 1937, 1938 and 1939. At several points comparison may be made between this group of cancers and the 100 previously reported.

In order clearly to stress important facts with as few statistics as possible, the discussion is given under three arbitrary divisions.

Characteristics of Cancer of the Bladder

Our knowledge of the etiology of cancer has not been increased materially in the last few years. But by studying a large number of cancers of the bladder we have acquired some valuable facts. We know that they are more likely to occur after the age of 50. In this group 74 per cent of the patients were between 51 and 71 years. Investigative procedures in this age group are particularly imperative if we hope to make an early diagnosis.

We do not question the fact that relatively benign epithelial tumors of the bladder do occur. However, the extensive and highly malignant cancers seen in this series suggest that the passage of time adds materially to the degree of malignancy. It indeed seems significant that we have never seen a highly malignant tumor of small size; that is, less than 1 cm. in diameter. The types of cancers seen cystoscopically or at operation are shown in the following chart:

Type	*Number*	*Grade*
Papillary	7	1 to 2
Infiltrating papillary	27	2—16 3 and 4—11
Flat infiltrating	13	3 and 4
Multiple tumors	4	2 and 3

From this picture it is easy to conclude that one characteristic of bladder cancer is its high degree of malignancy in approximately 50 per cent of observed cases. Certainly it can not be regarded lightly as a local growth. A complete report as to local and remote metastases is impossible as some of the patients died at home, some did not undergo operation, and in some autopsy was refused. Yet, in this small group, 10 per cent were found to have metastases either to bones or viscera. A cancer of the urinary bladder is no less dangerous than cancers in other organs of the body. It is well known that most of these growths occur in or near the trigone of the bladder. This characteristic causes another potent source of morbidity and mortality which was not easily recognized until the advent of the intravenous pyelogram—damage to the upper urinary tract. Sepsis and uremia not infrequently occur as a result of obstruction to the lower ureters. Much valuable information may be acquired by the intravenous pyelogram. We have come to regard it as a routine necessity and in this group it was done in all except two patients. The findings are given in the following chart:

EVIDENCE OF RENAL DAMAGE

Normal	25
Unilateral hydronephrosis	6
Functionless kidney	8
Bilateral hydronephrosis	5
Reduced function with severe pyelonephritis	5

Can the Patient Help Solve the Problem?

Our hopes for early diagnosis in cancer of the bladder must rest primarily upon the patient's reaction to objective symptoms. The lesion may begin silently, but hematuria will have occurred in 76 per cent as the first

* Presented at the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

symptom. This loss of blood should be dramatic enough for the patient to seek attention; however, such does not seem to be true. The bleeding is usually not copious nor is it continuous. The other associated symptoms of urinary frequency, dysuria and pain do not occur with sufficient severity to demand attention. As a danger sign demanding diagnosis, bloody urine is appreciated by the medical profession but not by the general public. The proof of this lies in the fact that 58 per cent of the patients in this series, and 55 per cent in the previous series, waited a year or longer after the first symptom before presenting themselves for examination. We are certainly not seeing cancer of the bladder any earlier today than we were five years ago.

Duration of Symptoms Before Hospitalization

1–4 weeks	3
2 months	6
3 months	4
6 months	6
8 months	2
1–2 years	13
2 years or more	17

The patient's second responsibility in this problem comes after treatment has been given. Because we know that cancer frequently recurs, the patient is advised to return for check-up examination at stated intervals. Failure to follow this advice leads to the loss of many lives that might otherwise be saved. Even without attaining the ideal end result called cure, a comfortable and long life may be attained by treating recurrences in their early stages. We have made a particular effort to explain these facts to this group of patients. That we have made some progress is evident when we note that in the former series only 10 out of 30 patients returned for follow-up examination, in the present report we have 19 patients living, and 15 of them have returned one to five times. The patients have cooperated to the best of their ability. Further increase of this 79 per cent return is likely to be minimal.

Surgeons' Choice of Therapy

After a careful evaluation of the physical status of the patient a cystoscopic examination of the bladder not only results in the diagnosis of cancer, but also determines the proper method of surgical treatment. Individualization of each case is necessary. Because these cancers vary widely in their degree of malignancy some method of classification is necessary. This may be done in two ways, either by description of the cystoscopic findings or grading them according to the biopsy. If the tumor is 1 cm. or less in size and has a small stalk in an otherwise normal bladder, we call it a malignant papilloma. Where the tumor is still papillary in type but of any size, with a somewhat thickened attachment to the bladder, we use the term papillary carcinoma. The flat or ulcerating cancers and the multiple papillomas need no explanation. The choice of treatment will usually be indicated by this classification:

Malignant papilloma	7
Papillary carcinoma	27
Flat infiltrating carcinoma	13
Multiple papilloma	4

Choice of Treatment

	Number	*Per cent*	*1937 Per cent*
Transurethral resection and fulguration	29	58	17
Cystostomy with fulguration (radium 1)	6	12	34
Resection of bladder	5	10	12
Cystectomy	2		
X-ray only	4		
No treatment	5		

Transurethral surgery was used whenever we thought the tumor could be destroyed properly. This decision was based on the accessibility of the tumor to the resectoscopic loop, the size, and the degree of malignancy. In addition, there were 4 patients with extensive cancers in whom the method was used as a palliative procedure. An increasing familiarity with transurethral surgery has led us to attack larger papillary tumors than was formerly the case. This accounts for the marked reduction in the use of cystostomy and fulguration which carried a higher mortality rate. The incidence of resection of the bladder has not changed because it is always used in the grade 3 and 4 cancers occupying resectable parts of the bladder wall. As 90 per cent of bladder cancers occur in or about the trigone, segmental resection will never be more than 10 per cent. Cystectomy remains a formidable operation, not because of the immediate surgical mortality but be-

cause we have no way of being sure in these extensive cases that the regional nodes are not involved. In addition to the 4 patients who had x-ray therapy as a palliative measure, 16 patients had x-ray treatment after surgery was done. Because x-ray is used most in the extensive cases, an evaluation is difficult.

Results

It is not pleasant to examine the results of treating cancer of the bladder. By a critical follow-up of these patients we hope to find an indication for future improvement. We were unable to find 7 patients, but they had extensive tumors so are classed as dead. Five patients died in this hospital and 27 died at home, leaving 19 patients who are now living one to three years after surgery. This is about the same percentage of living patients as was reported in the former series. At best we can say our treatment has improved but little; however, the surgical mortality has been reduced from 17 to 5 per cent. Of the 19 living patients, 17 were treated by transurethral surgery and 2 had segmental resection of the bladder. Certainly wide resection of the bladder offers the best hope of cure where it can be accomplished reasonably. Transurethral surgery gives just as good results in the papillary tumors as does open fulguration.

Summary

In our experience more than 50 per cent of cancers of the bladder are highly malignant, grades 3 and 4. The size of the tumor seems to have some relation to malignancy. Reduced renal function and urosepsis are common occurrences and may be the determining factor in the patient's failure to recover even without evidence of metastases.

The patient's cooperation is necessary if results are to be improved. Delay of diagnosis and treatment after the presence of hematuria is still a potent source of mortality. However, it has been shown that follow-up examinations can be done if sufficiently stressed to the patient at the time he is informed that a cancer is present.

In our hands the method of treatment has varied with the exception of the use of segmental resection of the bladder where possible. Transurethral treatment gives a lower surgical mortality and just as good survival rate as does open fulguration.

DISCUSSION

Cyril G. Richards, M. D., Kenosha: The paper by Dr. Wear supplements an excellent and more detailed report given by him five years ago before this Society. This included a detailed analysis of 100 cases of bladder cancer; today he adds 51 more. His statistics parallel those reported from time to time by other observers. He told you that we are still in the dark concerning the etiology of bladder cancer, but certain important basic facts which have been gleaned have resulted in a better understanding of certain types of this disease and their management.

It is evident that we are not seeing these patients early enough to have the best results. The information constantly given to the lay public through the press and various interested organizations has not produced the desired results. As shown in Dr. Wear's series, 58 per cent of patients with a history of hematuria did not present themselves for medical advice for a year or more after the beginning of symptoms, and 30 per cent waited two years or more. There has not been a urological meeting of major importance in the last twenty years that has not included a paper devoted to bladder cancer, and with a few exceptions, they all stressed the importance of education of the general profession and the lay public as to the seriousness of blood in the urine. The rank and file of general practitioners has heeded this advice, with a resultant early reference of cases. However, to the layman, hematuria so far has not become important enough to warrant seeking early advice.

Cancer of other parts of the body presents the problem of as complete surgical removal as possible. With bladder cancer we are faced with another and equally dangerous problem, that of sepsis leading to renal damage. Another reason for the high mortality is the failure of patients to return for frequent check-ups after initial therapy. A follow-up system should be used constantly to remind these patients of the necessity of frequent examination, and in smaller communities we are fortunate in that we can contact them readily. If we are to have a greater percentage of cures, the patients must be seen before there is deep infiltration of the muscular wall. As an example, the following case is cited:

A man 66 years of age had a history of hematuria of three months' duration. Cystoscopic examination showed a papillary tumor, 3 by 4 cm., situated on the posterior wall of the bladder near the dome, in a favorable place for resection. This was done with total removal of the growth. The microscopic diagnosis was transitional carcinoma, grade 3, with

(Continued on page 436)

A Study of 200 Deaths Associated With Cesarean Section—1934-1940 Inclusive*

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A STUDY of cesarean sections in Wisconsin presented in the April issue of this *Journal* showed that there has been a rather rapid increase in the number of cesarean sections done during the seven-year period, 1934 to 1940. Although the mortality from cesarean section is decreasing, it is still high. Since the 200 section deaths covered in this study constitute about one-fifth of all the maternal deaths, it is hoped by this analysis we can find some of the factors involved, and point out suggestions for prevention. Unfortunately, data collected from death certificates are often incomplete because physicians are unwilling to put down actual facts for fear of a malpractice suit. In view of the lack of information and often inaccurate data on certain death certificates, a cesarean section questionnaire was sent to every physician reporting a section death. This material has been kept entirely confidential. Between 1934 and 1940 there were 210 section deaths. The reporting was excellent; we have received data on 200 cases (95.2 per cent).

General Data

Prenatal Care.—Ninety-five and four-tenths per cent of the women received some type of prenatal examination. However, as compared with other studies we have done on prenatal care in Wisconsin, we found that the care seemed to start later, the majority of women contacting the physician for the first time during the second trimester.

Parity.—One hundred twelve, or 56 per cent, of this group were primigravids. We would expect this large number of primiparous patients in this study, since they show a larger percentage of disproportion, eclampsia, prolonged labor and uterine inertia.

Duration of Pregnancy When Section Was Performed.—Three-fourths of the sections were done at term. There were 25 sections done during the eighth month, and 15 during the seventh month. It is interesting to note that in 32 of these patients delivered before term, severe toxemic complications or ante partum bleeding was given as the indication.

Elective or Emergency Procedure.—Since these 200 women who died had what might be considered by some as adequate prenatal care, at least from the standpoint of time and the number of consultations, one would expect the number of emergency sections to be small. However, we find that 83.5 per cent were emergency procedures. Many of these complications could not have been foreseen, such as placenta praevia and premature separation of the placenta. However, in some instances the prenatal care must have been inadequate, otherwise, how would you account for 35 out of 37 cases of contracted pelvis and disproportion being classified as an emergency section, or 5 out of 8 cardiacs, or 7 out of 10 transverse presentations?

Fetal Mortality.—To this group there were born 205 babies, since there were 5 sets of twins. Among these there were 33 stillbirths and 25 infants who died before leaving the hospital. The fetal mortality in this series was 28.3 per cent, which seems high. The fetal mortality among the more common indications for section is shown in Table 1. In 31 cases where the operative indication was placenta praevia and abruptio placenta, the fetal mortality was 61.3 per cent; in 59 cases of eclampsia and other toxemias, 28.8 per cent; in 42 cases of prolonged labor, uterine inertia and malpresentation, 16.7 per cent; and in 37 cases of

* Presented at the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

disproportion and contracted pelvis, 2.7 per cent.

Irving,[6] in his review of cesarean section, gives the fetal mortality as 8.5 per cent. De Normandie[3] quotes the fetal mortality in Massachusetts as 9.14 per cent. The highest fetal mortality I could find was in King's[7] report from New Orleans. In his first series the mortality was 18.9 per cent and in his second series, 10.8 per cent. It should be pointed out, however, that all these other reports were from general cesarean section studies and were not restricted to cases in which death of the mother occurred.

Indications for Cesarean Section. — As Table 2 indicates, disproportion and contracted pelvis was the most common indication for cesarean section in these 200 patients. Eclampsia was next, being given as an indication in 15.5 per cent of the cases. Other common indications were toxemia, placenta praevia, prolonged labor, transverse presentation and premature separation of the placenta. Previous sections were mentioned in 3.5 per cent. One patient died following a cesarean section done because of a prolapsed cord, and there was one other case in which this was given as the indication on the birth certificate, but the physician failed to return the questionnaire. There were four instances in which the indication was stated as "desire of the patient or family."

When the indications for cesarean section on these 200 cases are compared with those for all sections reported in 1940, we find such indications as eclampsia, prolonged labor, malpresentation, and placenta praevia being far more frequent in the group that died, thus showing that cesarean section is often not the method of choice in handling these complications.

Type of Cesarean Section.—Nearly three-fourths of the sections were of the classical type; there were 49, or 24.5 per cent, low cervical sections done, and 11 radical or Porro sections. This is a slightly lower percentage of classical section than has been reported for the state at large. As the type of section is compared with the indication for section, we see there are a larger number of low sections done in the eclamptics, toxemias and cardiacs, while those patients developing some complication during the course of labor seem to be predominantly treated by classical section, which is contrary to our modern obstetrical teaching.

Cause of Death.—Considering this entire group, puerperal infections accounted for 46 per cent of the deaths. The other causes in order of their frequency were embolism and cardiac complications, toxemic complications, shock and hemorrhage, pneumonia and miscellaneous causes.

As Table 3 shows, the principal cause of death among both the low and classical sections was sepsis, the percentage being nearly the same. Of the patients delivered by low cervical section, 32.7 per cent died of embolism or some cardiac complications, as compared with 12.1 per cent of those delivered by classical section. Shock and hemorrhage accounted for 2 per cent of the low section deaths and 15 per cent of the

TABLE 1

SHOWING FATE OF CHILD AMONG THE MORE COMMON INDICATIONS FOR SECTION

Fate of Child	Placenta Praevia and Premature Separation	Toxemic Complications	Disproportion	Prolonged Labor	Contracted Pelvis	Eclampsia	Malpresentation	All Other	Total
No Data	0	0	1	0	0	0	0	0	1
Born alive—no data	0	0	0	0	2	0	0	0	2
Born alive—living	12	20	16	22	17	22	13	22	144
Born alive—died	7	2	0	2	1	7	1	5	25
Stillborn	12	3	0	2	0	5	2	9	33
Total	31	25	17	26	20	34	16	36	205

classical sections. Since nearly all patients with ante partum bleeding were delivered by classical section, this may account for the variation. The number of radical sections is too small to be statistically significant, but as one would expect, the majority died of shock or hemorrhage, since five out of the eleven radical sections were performed because of a ruptured uterus.

Table 4 brings out the fact that has been shown by so many previous authors, that as the length of time the patient has been in labor increases, the mortality due to sepsis also increases. Of the patients not in labor, 25.3 per cent died of sepsis, while of those in labor six or more hours, the percentage was 79.4. The same high incidence of infection was also shown in those having ruptured membranes, repeated vaginal examinations, and attempts at vaginal delivery.

Since the classical section does not offer adequate protection against infection in the potentially or grossly infected patients, it is important to consider information bearing on this point. Of the 140 patients delivered by classical section, 42.9 per cent were in labor six or more hours, 30 per cent had ruptured membranes, 32.1 per cent had had preceding vaginal examinations, and 9.3 per cent had even had previous attempts at vaginal delivery. Of these patients having classical section, 15 (23.1 per cent) not in labor died of sepsis, while 49 (70.0 per cent) of those who were in labor died of infection.

Of the 49 patients having a low cervical section, 46.9 per cent were in labor, 26.5 per cent had ruptured membranes, 22.5 per cent had preceding vaginal examinations, and in 8.2 per cent there had been attempts made at vaginal delivery. Of the low cervical patients not in labor 26.9 per cent died of sepsis, while 60.9 per cent who were in labor died of infection. At first glance one would judge that the low cervical section had little advantage over the classical section in prevention of infection. However, it must be recognized that the low cervical section has definite limitations, just as the classical sec-

TABLE 2

INDICATIONS FOR CESAREAN SECTION ON THE 200 CASES COMPARED WITH THOSE FOR ALL SECTIONS REPORTED IN 1940

Indication	Data on 1,439 Sections done 1940		Data on 200 Women Dying Following Section	
	Number	Per Cent	Number	Per Cent
Contracted pelvis and disproportion	572	39.7	37	18.5
Previous cesarean section	214	14.9	7	3.5
Toxemia	110	7.6	24	12.0
Placenta praevia	106	7.4	22	11.0
Reason not stated	70	4.9	----	----
Premature separation of placenta	45	3.1	9	4.5
Uterine inertia	40	2.8	7	3.5
Eclampsia	35	2.4	31	15.5
Prolonged labor	33	2.3	19	9.5
Elderly primipara	31	2.1	----	----
Breech	28	1.9	1	0.5
Other maternal complications	19	1.3	7	3.5
Occiput posterior	16	1.1	2	1.0
Transverse presentation	14	1.0	10	5.0
Previous pelvic surgery	13	.9	----	----
Elective procedure	13	.9	----	----
Maternal congenital defects	12	.8	----	----
Contraction ring	12	.8	2	1.0
Miscellaneous	11	.8	5	2.5
Other cephalic malpresentation	10	.7	2	1.0
Heart disease	9	.6	8	4.0
Ruptured uterus	8	.6	6	3.0
Fetal asphyxia	8	.6	----	----
Diabetes	4	.3	----	----
Prolapsed cord	3	.2	1	0.5
Fetal malformation	3	.2	----	----
Total	1,439	99.9	200	100.0

tion. As closely as can be determined in many instances, the usually accepted contraindications for both types of sections were not rigidly observed.

Discussion

As we have shown, the prenatal care was started early and the number of visits was adequate, but in view of the outcome, one cannot but wonder if the quality of the care was always the best. Despite the great publicity prenatal care has been given in recent years, in many instances we have sold only the name "prenatal care." The many aspects and proven values have not been accepted entirely or applied by all practicing physicians. We would like to think of prenatal care as Adair[1] does. He terms it maternal care which includes adequate preconceptional, prenatal, intra partum and postpartum care. If every patient received careful supervision through all phases of childbearing, we could either prevent or anticipate earlier many of these complications. It is realized that we cannot always evaluate each patient prior to labor, but many cases of contracted pelvis, disproportion, pelvic tumors and malpresentation can be determined prior to labor. It is the avoidance of as many of these emergency sections as possible that will help most in reducing our section mortality. De Normandie[3] showed that out of 1,196 elective sections, the mortality was 1.7 per cent, while in 995 emergency sections the mortality was 3.9 per cent.

In the majority of questionnaires in which contracted pelvis was mentioned as the indication for cesarean section, only the external pelvic measurements were given. The most important measurements, the inlet and the outlet, apparently were not taken. *Inlet contraction* can only be determined by observing disproportion between the fetal head and the symphysis, demonstrating whether the head can or cannot be pushed into the pelvis by external pressure, and measuring the diagonal conjugate. To determine *outlet contraction,* one must rely on the bi-ischial and the posterior sagittal measurements. It is only by combining the inlet and outlet measurements with the external measurements that one can determine whether a patient can or cannot be delivered from below.

While the indications for cesarean section have been broadened, there still are some definite contraindications. All but a very few obstetricians now feel there is no place for cesarean section in the treatment of eclampsia, yet in 1940, 35 eclamptics had cesarean section. In looking over the deaths associated with sections, we see that eclamptic deaths accounted for a large percentage of these fatalities. Of 31 patients who died, in which the operative indication was eclampsia, 21 (67.7 per cent) died directly from this complication; in other words, the section did not save them, and it may have even contributed to the death of some. Plass[9] has stated, "If an eclamptic survives a section, it is prime evidence she would have

Table 3

Cause of Death Compared With Type of Section
(200 Section Deaths, 1934–1940, Inclusive)

Cause of Death	Classical Section		Low Cervical Section		Radical Section		Total
	Number	Per Cent	Number	Per Cent	Number	Per Cent	
Sepsis	67	47.9	22	44.9	3	27.3	92
Toxemia	23	16.4	5	10.2	2	18.2	30
Shock—hemorrhage	21	15.0	1	2.0	6	54.5	28
Cardiac—embolism	17	12.1	16	32.7	0	----	33
Pneumonia	4	2.9	2	4.1	0	----	6
All other	8	5.7	3	6.1	0	----	11
Total	140	100.0	49	100.0	11	100.0	200

survived under conservative treatment." La Vake[8] has shown in a review of the literature that the mortality when eclampsia is treated conservatively is between 5.3 and 12 per cent; when treated by cesarean section, it varies between 15.0 and 42.7 per cent.

A sterile vaginal examination is still an important method of differentiating between the various causes of ante partum bleeding. Yet we find that out of 31 cases of diagnosed placenta praevia and premature separation of the placenta, only 45.2 per cent had had a preceding vaginal examination. In other words, the positive evidence for final diagnosis is lacking, yet the patient was delivered by cesarean section and died. One should also remember that all 31 mothers died, and two-thirds of the babies were lost.

In this study the number of fetal deaths was high, even for a group of patients that had serious obstetrical complications. Cesarean section is a hazardous operative procedure to undertake for any fetal indication and even more questionable when the child's chance of survival is poor. Nevertheless, we found that several sections were done in cases in which the indication was given as prolapsed cord, fetal asphyxia, or desire for living child. In these instances both mother and child died. Five section babies were either macerated or hydrocephalic. Cesarean section is contraindicated in such cases unless there is no other method of delivery. One should remember that cesarean section is not always a lifesaving measure and often results in a double tragedy.

The most alarming factors in Wisconsin are the failure to observe recognized contraindications and the improper choice of operative procedures. In 1927 Harris and Brown[4] provided very convincing evidence of the dangers of infection in women in early labor. By taking cultures from the uterine cavity at the time of cesarean sections in patients not in labor and in those in labor for varying lengths of time, they observed the following facts:

Uterus free of bacteria at the end of pregnancy.

Uterus free of bacteria within four hours after the onset of labor.

TABLE 4

CAUSES OF DEATH COMPARED WITH LENGTH OF TIME IN LABOR, CONDITION OF THE MEMBRANES, VAGINAL EXAMINATIONS AND ATTEMPTS AT VAGINAL DELIVERY

Classification	Puerperal Sepsis		Toxemic Complications		Shock and Hemorrhage		Cardiac Embolism		All Other		Total
Labor—no data	3	60.0	1	20.0	0	0.0	0	0.0	1	20.0	5
Not in labor	24	25.3	27	28.4	13	13.7	21	22.1	10	10.5	95
Labor—1–6 hours	6	40.0	0	0.0	6	40.0	3	20.0	0	0.0	15
Labor—6 or more	59	69.4	2	2.4	9	10.6	9	10.6	6	7.1	85
Total	92	46.0	30	15.0	28	14.0	33	16.5	17	8.5	200
Membranes—no data	3	50.0	0	0.0	1	16.7	1	16.7	1	16.7	6
Intact	45	33.3	29	21.5	22	16.3	26	19.3	13	9.6	135
Ruptured 1–6 hours	8	80.0	0	0.0	1	10.0	1	10.0	0	0.0	10
Ruptured—6 or more	36	73.5	1	2.0	4	8.2	5	10.2	3	6.1	49
Total	92	46.0	30	15.0	28	14.0	33	16.5	17	8.5	200
No data on vaginal examinations	1	25.0	0	0.0	1	25.0	1	25.0	1	25.0	4
No vaginal examination	55	40.4	27	19.9	16	11.8	28	20.6	10	7.4	136
Vaginal examination	36	60.0	3	5.0	11	18.3	4	6.7	6	10.0	60
Total	92	46.0	30	15.0	28	14.0	33	16.5	17	8.5	200
No data on vaginal delivery	1	33.3	0	0.0	0	0.0	1	33.3	1	33.3	3
No vaginal delivery	78	44.1	30	16.9	24	13.6	30	16.9	15	8.5	177
Attempted vaginal delivery	13	65.0	0	0.0	4	20.0	2	10.0	1	5.0	20
Total	92	46.0	30	15.0	28	14.0	33	16.5	17	8.5	200

After six or more hours, bacteria could always be demonstrated in lower uterine segment.

Absence of vaginal examinations by no means insures that the uterus is free of bacteria.

Even intact membranes do not offer a thoroughly effective barrier to the access of bacteria to the lower uterine segment.

Presence of normal temperature at the time of operation cannot be accepted as a reliable sign that bacterial invasion has not already occurred.

From these very valuable observations one may conclude that the classical cesarean section should be used only as an elective procedure or at the very start of labor. If classical section is used in any other way, it becomes a dangerous procedure, carrying a much higher mortality.

The low cervical section was devised for the potentially infected patient seen early in labor because it does offer more protection against infection. However, it should be recognized that the low cervical section does not offer such complete protection against infection that it can be substituted safely for the radical type section or the extraperitoneal section.

It is the opinion of most obstetricians that in the grossly infected patient, or even in the potentially infected patient seen late in labor, cesarean section should never be selected as the method of choice unless there is no other method of delivery. It is realized that in certain obstetrical complications this problem does arise and delivery cannot be accomplished from below. Then the Porro type section or extraperitoneal type of section should be selected. In Wisconsin we have resorted to other types of section too frequently in these cases. If a physician has to choose a Porro section as the method of delivering a grossly infected patient, he is practicing far more conservative and sound obstetrics than the individual who gambles with a classical or low cervical section under such circumstances.

One of the reasons many cases are not treated by the Porro section is that there is a widespread belief that the mortality from this operation is extremely high. Harris[5] reporting on 64 cesarean sections terminated by supravaginal hysterectomy noted a mortality of 4.68 per cent. However, only 1.56 per cent of the deaths could be attributed directly to the operation. Half of these were grossly infected, neglected patients seen for the first time late in labor. Had classical or low cervical sections been done on this group, the mortality no doubt would have been between 25 and 50 per cent.

Some obstetrical writers have mentioned that if the classical section were eliminated as an operative procedure, this would markedly reduce section mortality. There is no question that the low section should be chosen more frequently in Wisconsin, especially for the potentially infected patients seen early in labor, but this is not the whole answer. As an example, we find that during 1940, in Wisconsin, where 13.1 per cent of all the sections were of the low cervical type, the section mortality was 2.22 per cent. In Massachusetts during 1937, De Normandie[2] reported 54.4 per cent low cervical sections, with a section mortality of 3.1 per cent. One would expect that if the low cervical section alone would reduce mortality, Massachusetts with four times as many low cervical sections, would show a lower mortality. The wise selection of type of section must go hand in hand with rigid observation of the contraindications for cesarean section if our section mortality is to be reduced further.

Cesarean section contraindications which must always be kept clearly in mind are:

1. Operation without a valid indication.
2. Poor physical condition of the mother.
3. A dead or deformed child, except in the presence of an absolute pelvic indication.
4. Improper facilities for aseptic technique.
5. A patient infected from protracted labor, vaginal examinations performed with questionable antisepsis and asepsis, and rupture of the membranes.
6. Potential or frank infection.

Summary

"Hindsight" is always better than "foresight"; hence it is easy to interpret case studies on patients who have died and to draw the conclusion that if things had been done differently, the patient would have survived. It must be remembered that we do

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Comments on Treatment

Editor—A. J. QUICK, M. D., Marquette University, Milwaukee

Treatment of Prostatic Carcinoma by Castration or the Administration of Estrogen

Carcinoma of the prostate is one of the serious diseases of elderly men. It occurs in about 15 per cent of those who have prostatic obstruction. In many cases the diagnosis is made late in the course of the disease with the result that the malignant growth has invaded surrounding structures or has metastisized before treatment can be begun. In the cases that I studied last year, 60 per cent had x-ray evidence of metastasis and in the remaining the growth had so extended to the periprostatic tissue that surgical extirpation was not possible in any case. Since both x-ray and radium therapy are disappointing and since the former, particularly in our experience, often aggravates the condition, only palliative measures and relief of the obstruction by transurethral resection or suprapubic cystotomy were heretofore possible.

Recently, a promising new therapeutic approach to prostatic carcinoma has been developed. It had been known for some time that suppression of ovarian activity may retard metastasis of breast cancer. A similar inhibitory action on prostatic carcinoma by androgen suppression has been discovered: Huggins by surgical castration, Munger by x-ray castration, and Herrold by estrogen injection. These authors secured beneficial results in about 70 per cent of their cases and definitely demonstrated the superiority of the new method over the older therapeutic measures.

Androgenic suppression was applied to 33 patients. The diagnosis in 23 was made by biopsy; in the remaining 10, clinical findings sufficed. Of the entire group, 21 patients were castrated, while 12 were treated with stilbestrol alone. Of the 19 that were castrated but had received no stilbestrol, 15 are still living and of these, 10 have been materially benefitted. An additional patient with metastasis was very definitely improved, but died of apoplexy six months later. Of the patients treated with stilbestrol, 5 were definitely improved, 1 patient could not be followed, while in 4 the disease appeared to be progressing. Two patients were first given stilbestrol and later castrated, but without benefit.

On the basis of the rather short period of observation, improvement in over 60 per cent of the cases was observed, while 7 died, thus giving a mortality of 21.2 per cent. In addition to the castration operation, 4 patients were cystostomized in preparation for transurethral resection. Incidentally, 1 of these patients improved so much on stilbestrol that four months later the cystotomy tube was removed. The clinical improvement from androgen suppression was evidenced by increase in appetite and weight, improved blood picture, decreased sedimentation rate, and freedom from pain. The malignancy as palpated per rectum usually regressed in size, and often appeared softer. In none, however, has it been our feeling that the prostate gland returned entirely to normal. X-ray studies following castration or stilbestrol have not been conclusive of either recession or healing. In 2 patients very definitely improved, 1 by castration and the other by stilbestrol, metastasis first became evident two months after treatment. While the results are superior to the older methods, reserve must be exercised in evaluating the therapeutic findings, for we have followed 1 patient with biopsy-proven carcinoma for seven years, who has remained free of pain, and presents no clinical evidence of metastasis. At the present time, we do not feel that either castration or the administration of an estrogenic drug such as stilbestrol brings about a cure, but it does greatly improve and benefit the majority of cases of advanced carcinoma of the prostate.

—Charles R. Marquardt, M. D., Milwaukee.

Milk in National Health

An Interview with Prof. E. B. Hart

Chairman of the Section on Biochemistry, University of Wisconsin

Biochemistry—the chemistry of life—has had, over the last half century, a single goal: the enrichment of life for mankind.

Good health in animals has been studied, for from them man gets much of his food. New means have been arrived at for the preservation of food values. Scientific nutrition has permitted fullest use of all the vital health foods—vegetables, fruits, meats, and in particular dairy products—in the diet.

At the University of Wisconsin, as elsewhere in the country, the quest is unended and unending. Stephen Moulton Babcock and H. L. Russell devoted themselves to research and experimentation. E. B. Hart entered the field, and for four decades has done exceptional work in plant, animal and human nutrition. Hart heads a department which has numbered among its scientists such men as E. V. McCollum, Harry Steenbock, Conrad Elvehjem, and others, and which is giving inspiration to younger men building on the earlier foundations.

All these men seek one thing only; the chance to add to the world's effective knowledge. Their task does not, and cannot, end in the laboratory. They are doing their part to extend the practical application of their test-tube creations, just as Babcock and Russell and Steenbock speeded the way for man to apply the butterfat test, the tuberculin test for dairy animals, and the irradiation process for milk.

America owes them much for their efforts to make national good health a common thing, and not an unapproachable ideal.

—Karl H. Doege, M. D., Marshfield.

IF YOU had to choose a single food on which to live for the rest of your life, your wisest possible choice would be milk. That's the opinion of E. B. Hart of the University of Wisconsin biochemistry department. Milk is the only food which, without any help from other nutrients, could still give a healthful, balanced diet, he explains.

Of course the regular diet of milk, day after day, would have its disadvantages. It would get tiresome like any other one-food menu. But people have followed that ration for months at a time with satisfactory results on their health and well-being.

On the University of Wisconsin campus selected students have followed an all-milk diet for six-month periods, with only copper, manganese, and iron added. At the end of the experiment they have invariably been in as good or better physical condition than at the start. And while the record is being compiled, there's an authenticated case of a woman following an all-milk schedule for more than three years and retaining perfect health throughout the whole period.

Milk Adds to Any Menu

The significance of these tests is not the indication that milk can be an independently self-sufficient food, Hart points out. Their importance lies, instead, in the fact that they show what milk can add to any menu. Whatever the dietary deficiency, milk can usually contribute something to its correction.

It isn't right to say that milk has every needed food element. It is lacking in copper, iron, manganese, and vitamin D, and all of these food elements are especially needed by children and adolescents. But down the rest of the score card, through minerals and vitamins and proteins and fats and carbohydrates, milk qualifies.

Let's follow the score card through, starting with the vitamins.

"All the vitamins are present in milk in adequate quantities except vitamin D, and this can be added by several well-known practical methods," Hart observes. "The content of B-complex vitamins is fairly

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E. B. HART

abundant and also constant, due to the synthesis of these substances in the rumen of the cow."

In tabular form, here are the vitamins needed by man, together with the share of those vitamins supplied by milk.

The Vitamin	*Its Characteristics*	*How Milk Qualifies*
A	Oily, transparent, and fat-soluble. Helps maintain resistance to infection, promotes normal growth and normal teeth formation. Aids in maintaining highly accurate vision.	Milk is a good source, and particularly so if the cows have been fed a supply of vitamin A-producing feeds. Such feeds, in common use among Wisconsin dairymen, are legume silage, pasture and green leafy hay.
D	Necessary to proper use of calcium and phosphorus in the body. Consequently, it helps insure against poor bones and teeth.	Normally milk carries a negligible amount of this vitamin. Irradiated milk, however, is an excellent source.
C	Water-soluble. Important to the formation of supporting body tissues. Essential to proper maintenance of bones, teeth, and gum structure. Scurvy preventive.	Milk is an excellent source, a quart of milk offering up to a third of the normal day's needs.
Thiamin (B1)	The much-publicized "vitamin of morale." Essential to growth, carbohydrate utilization, and general health of the nervous system.	Milk is a superior auxiliary source. A quart of milk has from 0.3 to 0.5 mg. to the quart. Man needs 1.5 to 2.3 a day.
Riboflavin	Helps insure normal growth, skin health, and nerve structure. An enzyme in tissue respiration.	An adult needs 2 to 3 mg. daily. A quart of milk offers from 2 to 2.5.
Nicotinic acid (Niacin)	The antipellagra factor. A stable vitamin associated with skin health, digestion and nervous stability. Deficiency symptoms are nervous disturbances, diarrhea, skin disorders, and even pellagra.	Milk is less valuable than meats, for example, as a source of niacin. But a quart of milk can still supply up to a fifth of the daily needs.

The vitamin A in butter and cheese has a dramatic role in the present war, for RAF pilots in England follow a careful vitamin-A-rich diet to improve their eyesight for night flying.

Citrus fruits, tomatoes, and some other vegetables are important sources of vitamin C, but conditions seem to indicate that during the winter season a good many Americans who do not get these foods finish the year with cases of incipient scurvy. A quart of milk a day would go far toward correcting this situation.

Analyses for such vitamins as pantothenic acid, biotin, inositol, folic acid, and others have not yet been completed, nor has the function of these vitamins been completely clarified. However, in all major vitamin fields milk is important, and it seems likely that it will measure up equally well in these others.

Milk Rates High in Other Nutrients

Vitamins are of enormous importance to human health. But with the emphasis vitamins are getting in newspaper items, magazine articles, and food advertisements, the American public is beginning to believe they are the only food elements a person needs.

Nutritionists and physicians are not led astray. They know that there are other important food elements: minerals, sources of energy, and supplies of complete proteins. And nutritionists and physicians recognize that in these departments milk stands near first place.

Dairy Foods; the Best Source of Calcium

What are the minerals man must have? Well, let's see. Hart lists calcium and phosphorus for the teeth and bones, copper and iron for the blood stream, manganese, a reproduction factor, and all five for muscle-building and general body health.

Calcium and phosphorus, the bone-builders, appear abundantly in milk. Milk alone may not always supply enough phosphorus, but it always goes a long way toward filling the needs of that mineral. And for calcium, dairy products are a *must*. Calcium is not nearly so abundant and easily available in other major foods, as the traditionally poor teeth of the American people amply testify.

An adult needs about a gram of calcium daily, a pregnant or nursing woman requires up to two, and a child must have at least a gram or more. Milk supplies over a gram to

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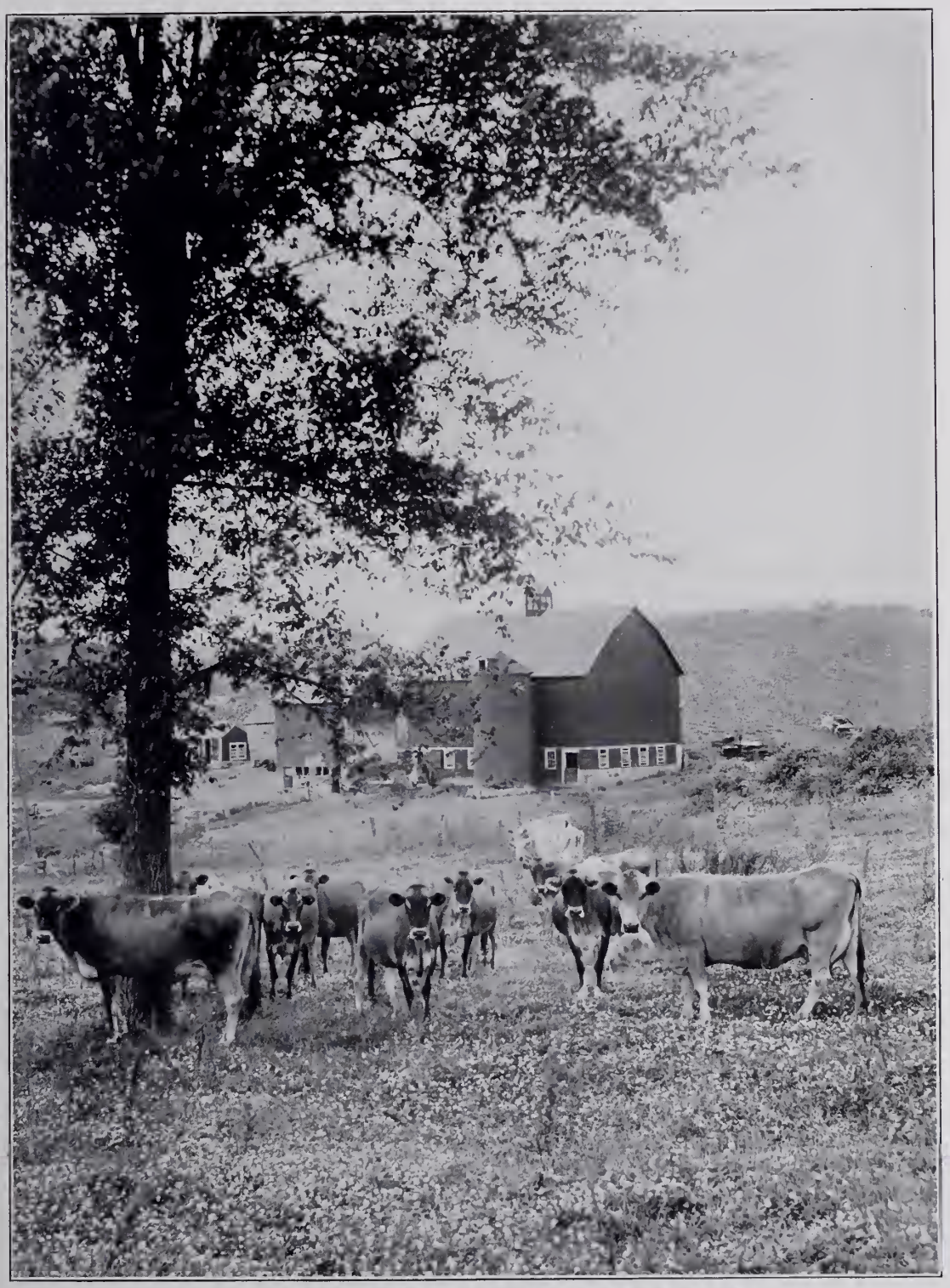

The Dairy Animal Yields Man's Richest and Most Complete Food.

the quart, and so the secret of good teeth and strong bones is inextricably tied up with dairy foods in the diet.

Copper and iron, important in blood-building, and manganese, which affects reproduction, do not appear in quantity in milk, primarily because milk is the natural food for the suckling young. The infant child or young animal is well-supplied with a large enough reserve of blood-building elements to last until he is old enough to turn to a natural copper or iron-supplying diet. But for the youngster, once weaned, until he has completed his years of growth and development, these minerals are vital. And though they are absent from milk, they appear in abundance in many green vegetables, and so should offer no danger of deficiency.

Iodine is an important mineral whose presence in the milk is dependent on the diet of the cow. It can be made to appear, if the cow is fed iodized salt or inorganic iodine. This process is practical, but unnecessary so long as iodized salt or sea food can fill the iodine needs easily.

How About Proteins?

Vitamins and minerals protect the body from infection and disease, at the same time supplying some materials for bone, tooth, and blood formation. Now another food constituent enters the picture: proteins, which provide material for the formation of strong muscular tissues.

Casein and lactalbumin are the significant dairy proteins, according to Hart. Milk includes other proteins, however.

Both casein and lactalbumin are physiologically complete; that is to say, they contain satisfactory proportions of all the amino acids which the body needs for balanced nutrition. In quality of protein, milk and eggs lead the entire field. And though meats offer a greater proportion of protein by weight than milk, the proteins of milk supply values which other foods cannot offer.

Milk Sugar Aids Metabolism

Not only does milk supply excellent proteins, but it also contains lactose, a sugar which has properties not found in other carbohydrates. Lactose encourages an acid reaction in the digestive tract, which diminishes putrefaction and the formation of toxic products which might be absorbed into the blood stream. It also assists in the utilization of calcium and phosphorus.

Whole milk is a fine source of fats, too. The fats of milk supply energy, and they also carry such fat soluble vitamins as A and K. The fats which appear in cream help in good body metabolism, as well.

"The fats of milk are of superior nutritive value," Hart points out. Not only do they supply vitamin A, but another element which makes whole milk a fine food for the young, the newly discovered fat growth factor. That element appears to be a saturated fatty acid which actually plays the part of a vitamin and is especially important to young animals. The factor has not been isolated nor identified, but it appears to exist only in animal fats. Thus reinforcement of vegetable oils with all the fat soluble vitamins now isolated still leaves those oils inferior as a food for the very young.

Milk fats are almost completely digested and used in the body, and though most fats can claim that same distinction, butterfat has some advantage. Physicians recognize this in their treatment of gallbladder patients, when they permit the free use of butter and cream, but prohibit other fats.

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SCIENTIFIC PROTECTION

The quart of milk appears on the front porch almost magically every morning.

It's there when you get up.

It's ready for your early morning breakfast.

. . . But there's no magic involved in milk production and distribution. There's only a long and necessarily complicated process, the essence of which is speed, and at the same time complete protection for the consumer.

THE NATION AT WAR

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Present Status of Procurement of Medical Officers in the United States Army

By LIEUTENANT COLONEL AMORY A. MILLER
Infantry, U. S. Army

BECAUSE of the necessity of securing needed medical officers for the military and naval services in such a manner as to insure that no civilian community is stripped of essential medical, dental, and veterinary personnel, the American Medical Association urged that the services of their organization be utilized in this procurement program. This plan was approved by the President of the United States. As a result, the Procurement and Assignment Service, Office of Defense Health and Welfare Services, was established in Washington, D. C., and all offers of service by medical personnel have been routed to this office for clearance.

While this plan was proceeding in an orderly manner, there has been considerable delay in completing applications, which has resulted in procurement of medical officers lagging behind the needs of the rapidly expanding military. In order to expedite the appointment of medical officers, there has been established in our state an agency known as the Medical Department Officer Recruiting Board for the State of Wisconsin, with headquarters at 559 Federal Building, Milwaukee. This board has authority from the Surgeon General and the Adjutant General of the Army to commission qualified members of the medical profession between the ages of 24 and 44 inclusive in the grades of first lieutenant and captain, Medical Corps, Army of the United States. Applications from physicians between the ages of 46 and 54 inclusive will be accepted, but in this group action will be taken by the Surgeon General of the Army.

The procedure in making the application is as follows:

1. Write the Medical Department Officer Recruiting Board, 559 Federal Building, Milwaukee, for authority to take required final physical examination. Final examinations are made at:

   Station Hospital, Fort Snelling, Minnesota
   Station Hospital, Fort Sheridan, Illinois
   Station Hospital, Camp Grant, Illinois
   U. S. Dispensary, Headquarters Sixth Corps Area, U. S. Post Office, Chicago

2. Upon indication that applicant is physically qualified, the necessary papers will be forwarded for completion. This insures that the professional qualifications of each medical applicant are recorded for use in making future assignments.

3. Availability must be certified through the Wisconsin office of Procurement and Assignment. This information can be obtained through the Medical Department Officer Recruiting Board.

4. Applicant must obtain statement from local draft board to include classification, if classified, and that orders for induction have not been issued. **Note: If orders for induction under Selective Service have been issued, the Medical Department Officer Recruiting Board is without authority to grant the commission in the Army.**

5. The oath of office and commission are administered by the Medical Department Officer Recruiting Board. The members of the board are:

   Lieutenant Colonel Amory A. Miller, Infantry
   Captain Norman L. Sheehe, Medical Corps

Assisting the board as representatives of Procurement and Assignment Service are:

Robert E. Fitzgerald, M. D.
Charles Baumann, D. D. S.
W. Wisnicky, D. V. S.

Selective Service and Procurement and Assignment

The following memorandum was sent to all local boards on April 24, 1942:

To: Local Boards

Re: Procurement and Assignment Service

There appears to be considerable misunderstanding regarding the operation of the Procurement and Assignment Service, referred to in CLA–18 (Supp. 9).

The executive order which created the service in no way affects the authority of the Selective Service System to classify registrants. The procedure was established to make information available to Local Boards.

With this understood, we can undertake a general statement regarding the procedure to be observed by the Local Board in classifying a medical doctor, dentist, or veterinarian.

1. Before classifying a member of such professions, the Local Board, acting through State Headquarters, should secure an expression from the Procurement and Assignment Service. Such expression should be looked upon as a statement from the Procurement and Assignment Service as to whether, based upon information in its hands, the registrant can be spared from the community where he practices.

2. A statement that the registrant is urgently needed as an active practitioner in his community should weigh heavily in favor of deferment, and the Local Board, in the absence of strong evidence to the contrary, should be extremely hesitant about rendering a 1-A classification.

3. When the Procurement and Assignment Service submits a statement that the registrant's professional services as a civilian can be spared by his community, and the Local Board lacks authentic information to the contrary, a 1-A classification is in order.

4. When the Local Board has determined upon a 1-A classification, and the registrant has been informed of that fact, he should be accorded a stay of induction for a reasonable period to apply for and secure a commission.

5. If, after the lapse of a reasonable stay of induction, the registrant does not make application for and receive a commission, he may then be ordered to report for induction.

For the Governor,
(Signed) John F. Mullen
Colonel, Infantry, AUS
Acting State Director

Statement Re Deferment From Military Service, by Dr. Harold S. Diehl, member of the directing board of Procurement and Assignment Service:

"The attitude of the directing board of Procurement and Assignment Service and of officials of the national headquarters of Selective Service, in regard to granting deferment from military service to physicians on account of dependents, is that since physicians can enter service in the rank of commissioned officers, deferment on account of dependents or financial hardship is rarely, if ever, justified. The initial pay of a first lieutenant who is married amounts to $3,152 per year. This is considered adequate to cover the essential needs of an officer's family."

Regulations Governing Grants to Hospitals For Establishing Reserves of Blood Plasma

DR. JOHN S. COULTER, regional medical officer of the Office of Civilian Defense, urges all hospitals of approved size, etc., to submit letters of application under the regulation governing grants-in-aid to hospitals for the formation of blood and plasma banks. Because of limited funds, for the rest of this fiscal year at least, grants must be limited to hospitals within 300 miles of ocean or Gulf Coast, and there will be only a tentative allocation for grants, if any, in the Sixth Corps Area. However, there will be compiled a complete inventory of the needs of all states for possible use next fiscal year when the program may not be so limited, and letters of application should be sent direct to the Office of Civilian Defense, Washington, D. C.

The complete memorandum from the Federal Security Agency of the United States Public Health Service follows:

WHEREAS, on April 11, 1942, there was allotted from the "Emergency Fund for the President" to the United States Public Health Services the amount of $292,500, "to be expended by said Public Health Service in connection with emergencies affecting the national security and defense for procuring and establishing either independently or, subject to regulations to be promulgated by the Surgeon General, by grants to public and private hospitals located not more than 300 miles from ocean or Gulf Coast, reserves of liquid, frozen or dry blood plasma or serum albumin for the treatment of casualties resulting from enemy action," the following regulations are promulgated to govern the administration of this allotment:

Section I. Eligibility For Grants

Preference shall be given to hospitals serving communities whose geographical location implies a likelihood of civilian casualties from enemy action, and which are inadequately equipped to handle such casualties.

To be eligible for a grant a public or private hospital located not more than 300 miles from ocean or Gulf Coast* shall:

(1) Have a capacity of not less than 200 beds, exclusive of bassinets, provided that two or more smaller hospitals totaling 200 beds may submit a cooperative project designating one of the participating hospitals as the grantee;

(2) Be on the approved list of the American College of Surgeons and the Hospital Register of the American Medical Association;

(3) Have on the professional staff a physician whose qualifications are the equivalent of those required by the American Board of Pathology for its diplomates.

Section II. Approval of Plans

A grant shall cover a period of not more than twelve months following the approval of the plan, or not beyond June 30, 1943, and may be used only for the purchase of equipment necessary for the preparation of liquid or frozen plasma, reconditioning or minor alterations of existing quarters, necessary travel and subsistence allowance of $6.00 per diem to cover a training period, if required, of not more than one week, for the physician directing the blood plasma project, and temporary salaries of personnel necessary for the establishment of a blood and plasma project.

A Hospital desiring to receive a grant shall submit a plan to the Chief Medical Officer, Office of Civilian Defense, who is authorized to receive such plans on behalf of the Surgeon General of the United States Public Health Service. A plan shall contain the following information:

(1) The number of hospital beds classified according to use;

(2) The name and qualifications of the physician who will direct the plasma project.

(3) Description of present blood and plasma project, if any;

(4) The type and amount of plasma reserves which the institution desires to prepare;

(5) The delivered price of equipment necessary to complete the existing facilities for preparing such plasma—such items to be numbered and described in accordance with the equipment inventory in "A Manual on Citrated Normal Human Blood Plasma," issued by the Office of Civilian Defense, or equivalent approved substitute equipment;

(6) The materials or labor, if any, needed for adapting existing quarters to the needs of the blood plasma project;

(7) The salaries, if any, to be paid additional personnel until the plasma reserve has been prepared. Salary items shall also show the proposed periods of employment for each individual and the proposed monthly rates of pay.

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* Note: the Appropriation Act for the fiscal year 1943 may not limit grants to hospitals within this geographical area.

When a plan is recommended by the Chief Medical Officer of the Office of Civilian Defense for the approval of the Surgeon General, the hospital will be furnished a budget and acceptance form to be signed, notarized and returned to the Chief Medical Officer, Office of Civilian Defense.

Section III. Conditions of Grants

(1) The hospital shall agree to build up a plasma reserve of at least one unit per bed within three months after delivery of the necessary equipment. A unit of plasma is that amount derived from 500 cc. of citrated whole blood, consisting of about 250 cc. of liquid plasma;

(2) The agreed amount of plasma reserve shall be maintained for use without charge and only for treatment of casualties caused by enemy action. The reserve shall be released for use in other local hospitals for this purpose on order of the local Chief of Emergency Medical Service and for transfer within the State on order of the State Chief Emergency Medical Service, or transfer from one State to another on the order of the Regional Medical Officer, Office of Civilian Defense;

(3) Liquid plasma shall be kept from being outdated by replacement of older by newer plasma. Replaced units may be utilized for current needs of the hospital in the treatment of its regular patients, provided the plasma reserve shall not be allowed to fall below the stated minimum;

(4) All plasma shall be prepared in accordance with manuals of the Office of Civilian Defense prepared by the Subcommittee on Blood Substitutes of the National Research Council;

(5) The hospital shall agree to continue the plasma project for its current needs after the expiration of the Federal Grant and to maintain for the duration of the war the minimum stated reserve; thereafter the reserve may be used by the hospital without restriction;

(6) A record shall be kept of all blood donors, including their blood types, to expedite obtaining donors for emergencies;

(7) No funds made available under the grant shall be used for the payment of blood donors;

(8) Any blood plasma project under this program shall be subject to inspection by authorized representatives of the Surgeon General of the Public Health Service.

Section IV. Method of Payment

Payments will be made on a reimbursement basis for expenditures made in accordance with the approved budget. Applications for reimbursement shall be notarized and addressed to the Chief Medical Officer, Office of Civilian Defense. The procedure for payment will be as follows:

(1) Payments from the allotment to cover the purchases of non-expendable equipment aggregating $300 or more will be paid upon receipt from the authorized administrative head and accounting officer of the hospital, of an itemized statement of the purchases supported by invoices showing the date of delivery of such equipment;

(2) Payment will be made for the authorized training expenses of the physician who is to direct the blood plasma project whenever the hospital presents a notarized claim itemizing the travel and per diem allowance incident to the training;

(3) Reimbursement for other items of the approved budget will begin only after actual production of blood plasma is started. During the first three months of production, reimbursement will be made on a monthly basis and quarterly thereafter for the duration of the grant. Such reimbursement will be made only upon receipt of a report form prescribed by the Surgeon General from the institution showing expenditures incurred during the period, total plasma prepared during the month, and the total reserve on hand to date;

(4) Payments may be withheld, and plasma produced as part of this project may be transferred by the Surgeon General, from any hospital which fails to meet the conditions of the grant or to comply with the regulations;

(5) Each hospital shall submit monthly reports during the period of the grant showing the amounts of plasma on hand and used; thereafter, for the duration of the war the hospital shall submit such reports quarterly on its use of the plasma;

(6) Hospitals shall submit promptly reports including clinical abstracts of any untoward experiences encountered in the use of plasma for the duration of the war.

Wisconsin's Emergency Medical Service Progress Commended by Drs. MacEachern and Coulter. — At the War Sessions of the American College of Surgeons held in Madison on May 4, both Dr. M. T. MacEachern, associate director of the American College of Surgeons, and Dr. J. S. Coulter, medical officer of the Sixth Civilian Defense Region, commended the physicians of Wisconsin for their efforts in developing Emergency Medical Service. "The organization and preparation of Emergency Medical Service displayed here today is far superior to anything we have witnessed at these War Sessions in twenty-five states," was the statement of Dr. MacEachern in commenting on the display of the Dane County Emergency Medical Service in the lobby of Hotel Loraine where the War Sessions were held.

The Nation's Freedom Bonds

AMERICA today needs the help of every citizen in the nation's fight for freedom. As physicians and surgeons, we of the State Medical Society of Wisconsin are already doing our part. But we must do more than this. As members of a united civilian force, we must invest our dollars in the country's all-out war effort. War is expensive but it will be cheaper to win than to lose this war. Victory is our goal—no matter how great the cost. And we must help pay the bill.

A part of the necessary money will come through the victory tax program. But tax revenues do not meet the annual costs of war. A part will be obtained from banks and other lending agencies, but large loans from such sources expand the credit structure and contribute to inflation. In order to meet the total cost, the Government must secure billions of dollars directly from the people through the Defense Savings Program. The dollars invested in Defense Bonds are withdrawn from consumer purchasing power, which helps curb inflation. At the same time, the bonds represent savings for individuals which increase in value as much as 33⅓ per cent. Every penny is backed by the full faith and credit of the United States Government, and a loan may be recalled if the bond owner so requests.

There are bonds for all individuals and associations among the three series of Defense Savings Bonds which the Treasury Department offers. Series E Bonds, "The People's Bonds," can be bought only by individuals. These are appreciation bonds which, if carried through to the ten-year maturity date, provide an average annual return of 2.9 per cent upon the investment. The smallest E Bond costs $18.75 and pays $25 at maturity. Others cost from $37.50 ($50 maturity value) to $750 ($1,000 maturity value). A bond of this series may be registered in the names of one or two persons or in the name of one person with a second listed as beneficiary. All post offices and most banks sell "The People's Bonds."

Series F Bonds, like the Series E, are appreciation bonds, but these may be bought by corporations and associations as well as individuals. These are twelve-year bonds, which provide a return equivalent to an annual interest rate of 2.53 per cent. The smallest of this series costs $18.50 and pays $25 at the end of twelve years; the largest costs $7,400 and pays $10,000 at maturity.

The bonds of Series G, unlike those of Series E and F, are sold at par; that is, the cost is the same as their face value. But also unlike Series E and F, Series G Bonds pay interest semiannually at the rate of 2½ per cent throughout their twelve-year

maturity period. Bonds of this series are issued in denominations ranging from $100 to $10,000. Only the Treasury Department and Federal Reserve Banks issue F and G Bonds, but most commercial banks accept applications for them.

The minimum costs of E, F and G Bonds are $18.75, $18.50 and $100, respectively. But these are not the smallest amounts that can be invested in Defense Savings. Smaller amounts of money purchase Defense Savings Stamps which range in price from 10 cents to $5. When the equivalent of a minimum price bond has been invested in Defense Stamps, they can be turned in for one of the registered interest-bearing bonds.

We, as a United Nation, face the future with grim determination. This is total war, and each of us must accept his responsibility for the job to be done. A part of this job is the budgeting of dollars. We must buy and continue to buy the nation's "freedom" bonds.

THE WISCONSIN MEDICAL JOURNAL

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Annual Subscription ---------- Three Dollars-Fifty Cents Single Copies ---------- Fifty Cents

Advertising Representative: Cooperative Medical Advertising Bureau, 535 North Dearborn St., Chicago, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, Madison

Volume 41 — MAY, 1942 — Number 5

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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« « « EDITORIAL » » »

Remember Pearl Harbor

THE medical profession, even as the laity, has cause to "Remember Pearl Harbor." It was truly a day of infamy in modern history. But we may nevertheless consider with a measure of pride the fact that the medical profession of Hawaii through its Committee on Medical Preparedness was ready when the need arose.

The January issue of the *Hawaii Medical Journal* reveals that citizens were not as yet protected by adequate black-out systems, control centers, fire-fighters or air-raid precautions. "Our office of Civilian Defense existed only in skeleton form, and largely on paper," says the author of the article in the *Hawaii Medical Journal* who added "Only the medical defense offices, under the auspices of the Medical Preparedness Committee of our county medical society, were actually organized and operating. Within an hour 18 first-aid units went into action, and the Preparedness Committee had 100 trucks rolling within an hour, some immediately, to the scene of combat at Hickam Field and Pearl Harbor for the transportation of casualties to the Army Hospital."

We in the United States have difficulty in believing that the direct catastrophes of war may occur within the continental confines of our country. Even those in Hawaii related that "It took some time for the transition to take place in the minds of all of us that this was not a maneuver, that the Japanese had actually arrived—an utterly inconceivable reality." But we must recall that the airplane has in many ways demolished space, that a country at war acts quickly and in immense ways, that sabotage, quite as often as direct attack, is the favored weapon of those who would destroy us.

Emergency Medical Service is rapidly being organized in each community of the state. Each community activity is ultimately integrated into the state program, each state program into the national picture. Give the activity in your community a hand. It is one of the necessary ways to win the war.

. . . . THE PRESIDENT'S PAGE . . . .

Appraisal

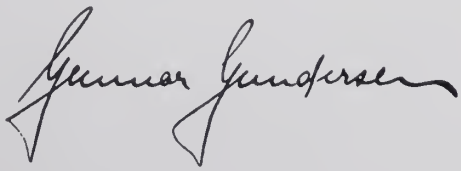
REALIZATION comes to the American people that an all-out war is not alone a struggle of war machines at the front but wherever effort becomes necessary to assure ultimate victory. War is wherever it may be found, and in this War of Survival it may be found over the entire world. Battle lines are no longer the only scene of clash, as the modern weapons destroy space and time and geographical barriers. All-out war means that the nation's people fight side by side in the bucket-line of productive effort.

With the nation, Our Country, at war, personal sacrifice becomes the privilege and honor of each of us. Certainly the medical profession has ever been cognizant of its responsibility in time of emergency, and this occasion finds no exception. Preparedness of the medical men began months ago. Fully cognizant of what the past has taught us, the medical profession was firm in its determination to develop those procedures which would assure its most efficient assistance to its country's war efforts.

Thus was developed the Procurement and Assignment Service for Physicians, Dentists and Veterinarians, in the Office of Defense Health and Welfare Service of the Federal Security Agency. Created by order of President Roosevelt, and under the able guidance of a directing board of which Dr. Frank H. Lahey of Boston is chairman, and for which Dr. Sam F. Seeley serves as executive officer, the Procurement and Assignment Service is charged by the medical profession itself with the two fundamental tasks of assuring proper community protection while providing the armed services with medical men qualified for particular assignments.

Perhaps by the time this *Journal* is in the mail there will be on the desk of every physician in the country a questionnaire calling for detailed information relating to training, experience and personal data. It becomes the duty of each of us to give that cooperation which we as a medical profession seek. It becomes our duty and our privilege to comply promptly with this request, regardless of our age, our practice, or our individual problems. As Dr. Irving Abell so truly said, "The medical profession with its education, training, experience, and convictions, is ready now to assume responsibility, as it has done in the past, for the care of all people, whether in industry, in the armed forces, or in the civilian population." No statement can be made which with greater clarity could express that which is in the mind of each of us in the medical profession.

And as we display our certificate of enrollment in Procurement and Assignment, and wear the lapel button as our badge of honor, we can know again that satisfaction which is a priceless heritage of medicine,—once more we are prepared to serve as best we can.



THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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Program of the Annual Meeting, Woman's Auxiliary to the American Medical Association

Atlantic City, New Jersey, June 8-12, 1942

Haddon Hall, Headquarters

MRS. DAVID B. ALLMAN, *Chairman*
Committee on Local Arrangements

HOSTESSES

Woman's Auxiliary to the Atlantic County Medical Society

Woman's Auxiliary to the Medical Society of New Jersey

A MOST cordial invitation is extended to all women who are Auxiliary members or guests of physicians attending the convention of the American Medical Association, to participate in all social functions and to attend the general sessions. Whether Auxiliary members or not, wives of doctors will be most welcome.

Auxiliary headquarters will be on the Lounge Floor of Haddon Hall. All meetings and functions will be held at Haddon Hall unless otherwise stated in the program. Please register early and obtain your badge and program of the sessions and social functions.

All tickets should be purchased soon after arrival. Tickets will be sold only at Auxiliary headquarters in Haddon Hall. Members of the Hospitality and the Information Committee will be at the hotels and at the guests' registration desk at Convention Hall. They will gladly help you plan for an interesting visit in Atlantic City. All meetings and social affairs will begin at the time scheduled. Please be prompt.

Registration hours:	A. M.	P. M.
Sunday	11:00	4:00
Monday	8:30	4:00
Tuesday	8:30	4:00
Wednesday	8:30	4:00
Thursday	8:30	4:00
Friday	8:30	4:00

Auxiliary members may register *only* at headquarters in Haddon Hall.

Guests may register at headquarters or at the woman's registration desk in Convention Hall.

PRECONVENTION MEETINGS

Sunday, June 7

2 to 4 P. M. The members of the Hospitality Committee will welcome members and guests of the Woman's Auxiliary.
Chairman—Mrs. Joseph Poland

7 P. M. Finance Committee Meeting
Chairman—Mrs. Harold F. Wahlquist

OUR NATIONAL MEETING

A most cordial invitation has been extended to all members of the Woman's Auxiliary to attend our national convention in Atlantic City, June 8 to 12. All wives of doctors, whether or not they are members, will be most welcome.

Not only is Atlantic City a stimulating center for our meeting, with its proximity to national and historic places of interest, but the program planned is one to invite our personal and organizational support. Pan-American problems of medicine and cooperation will be emphasized, with Dr. Raimundo De Castro of Havana, Cuba, as one of our guest speakers.

Mrs. Frank Haggard, our national president-elect, in her thoughtful and timely article, "The Woman's Auxiliary in Wartime," in the current *Bulletin,* reminds us that,—

"Coming together is a beginning
Keeping together is progress
Working together is *success.*"

If you can, send in your reservation now for our meeting in June so that we may share in the refreshment that the knowledge and closer touch with our national program gives us.

—MRS. J. S. SUPERNAW, *President.*

Monday, June 8

9 A. M. to 12 Noon. Meeting of Board of Directors —Committee Room D, Lounge Floor
Presiding—Mrs. R. E. Mosiman

12:30 P. M. Luncheon in honor of president-elect, Mrs. Frank Haggard. Guests will be the past-presidents and the members of the Advisory Council. Mrs. R. E. Mosiman, hostess.

4 to 6 P. M. Tea honoring Mrs. R. E. Mosiman and Mrs. Frank Haggard will be given for members of the National Board of Directors and guests at Haddon Hall, Garden Room, Lounge Floor.

GENERAL MEETINGS

Tuesday, June 9

9 A. M. Formal Opening of the Convention of the Woman's Auxiliary to the American Medical Association at Haddon Hall, Vernon Room, Lounge Floor
Presiding—Mrs. R. E. Mosiman
Invocation—Rev. Warren W. Way, D. D., St. James Episcopal Church, Atlantic City, New Jersey
Address of Welcome—Mrs. J. H. Hornberger
Response—Mrs. William J. Butler
In Memoriam—Mrs. Joseph E. Wier
Introduction of Mrs. David B. Allman, Chairman of the Committee on Local Arrangements
Greetings—Dr. William J. Carrington
Minutes of Nineteenth Annual Meeting—Mrs. S. H. Flowers
Roll Call—Mrs. S. H. Flowers
Reports of Chairmen of Convention Committees
Credentials and Registration — Mrs. R. J. McDonald
Convention Rules—Mrs. E. Latane Flanagan
Resolutions—Mrs. Arthur A. Herold
President's Message—Mrs. R. E. Mosiman
Presentation of the President-Elect, Mrs. Frank Haggard
Reports of Officers
Recording Secretary—Mrs. S. H. Flowers
Corresponding Secretary—Mrs. R. E. Ahlquist
Treasurer—Mrs. D. W. Thomas
Auditor—Report to be read by Recording Secretary
Reports of Chairmen of Standing Committees
Archives—Mrs. Charles E. Sears
Exhibits—Mrs. Ily R. Beir
Finance—Mrs. Harold F. Wahlquist
Hygeia—Mrs. George R. Dillinger
Legislation—Mrs. Jesse D. Hamer
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Program—Mrs. William Hibbitts
Public Relations—Mrs. Frank P. Dwyer
Revisions—Mrs. Eustace A. Allen

Reports of Chairmen of Special Committees
Circulation of the Bulletin—Mrs. Charles H. Werner
Supplies—Mrs. J. E. Purdy
Report of Historian—Mrs. John J. Ryan
Report of Parliamentarian—Mrs. R. E. Fitzgerald

12:30 P. M. Luncheon in honor of past-presidents of the Woman's Auxiliary to the American Medical Association in Rutland Room, Haddon Hall. Tickets $2.
Guest Speakers: Dr. Frank Lahey, President, American Medical Association; Dr. W. W. Bauer, Director, Bureau of Health Education, American Medical Association; Mrs. Augustus S. Kech, Director of Health Education, Department of Health, Commonwealth of Pennsylvania.

2:30 P. M. Conference for Presidents and Chairmen of Standing Committees of State Auxiliaries.
Presiding—Mrs. John L. Bauer and Mrs. Frank Haggard

8 P. M. Opening Meeting of the Convention of the American Medical Association, Ball Room, Convention Hall.
Members of the Woman's Auxiliary and guests are welcome.

Wednesday, June 10

9 A. M. General Session Woman's Auxiliary to the American Medical Association, Vernon Room, Lounge Floor.
Presiding—Mrs. R. E. Mosiman
Minutes—Mrs. S. H. Flowers
Announcements
Report of the Convention Committees
General Chairman—Mrs. David B. Allman
Credentials and Registration — Mrs. R. J. McDonald
Resolutions—Mrs. Arthur A. Herold
Courtesy Resolutions—Mrs. Oswald R. Carlander
Reports of the State Presidents
Report of the Nominating Committee—Mrs. Augustus S. Kech
Election of Officers
Installation of Officers—Mrs. J. Newton Hunsberger
Presentation of President's Pin
Inaugural Address—Mrs. Frank Haggard
Minutes—Mrs. S. H. Flowers

12:30 P. M. Annual Luncheon, Rutland Room
Tickets $2.
Presiding—Mrs. R. E. Mosiman
Greetings—Dr. Arthur W. Booth
Guest Speakers: Dr. Fred Rankin, President-Elect of the American Medical Association; Dr. Morris Fishbein, Editor of the Journal of the American Medical Association; Dr. Charles Gordon Heyd, member of the Board of Trustees of the National Physicians Committee.

Thursday, June 11

9:30 A. M. Executive Committee Meeting, Solarium, Lounge Floor
Presiding—Mrs. Frank Haggard

10 A. M. Board of Directors Meeting
Presiding—Mrs. Frank Haggard

6:30 P. M. Annual Dinner for Members, Husbands, Guests, Rutland Room, Haddon Hall. Tickets $3.
Guest Speaker—Dr. Raimundo De Castro, Havana, Cuba

9 P. M. Reception and Ball in Honor of the President of the American Medical Association, Hotel Traymore.

Friday, June 12

Shopping and sightseeing under the direction of the Hospitality Committee.

County Auxiliary Proceedings

Brown—Kewaunee—Door

Mrs. A. O. Olmsted was hostess to members of the Woman's Auxiliary to the Brown–Kewaunee–Door County Medical Society at their regular meeting on February 23. Mrs. E. S. Schmidt, president-elect of the State Auxiliary who will take office in September, was the speaker of the afternoon, presenting a talk on "Our Defenses in Newfoundland, Greenland, Iceland and Alaska."

The social chairman, Mrs. J. E. Halloin, was assisted by Mrs. W. W. Kelly and Mrs. T. S. Burdon. Mrs. L. D. Quigley poured at the tea table, and Mrs. George Goggins presided at the business meeting. About twenty-five members were present.

Mrs. E. J. O'Brien, publicity chairman, reports that a class in defense nutrition has been formed by Auxiliary members at the Green Bay Vocational School, and meets for a two-hour period every Wednesday morning. Members are also sewing for the Red Cross, and several contributed their services on draft registration day, February 16.

"A volunteer group fighting to save lives rather than destroy lives," is the definition of the Women's Field Army of the American Society for the Control of Cancer, according to Mrs. G. E. Stoddart, Beaver Dam, state commander, who spoke on March 25, at a joint meeting of the Brown–Kewaunee–Door County Auxiliary and the Green Bay and De Pere units of the Women's Field Army.

Presiding at the meeting was Mrs. George Goggins, president of the Auxiliary. The speaker was introduced by Mrs. John Victor, lieutenant of the local Army units.

Mrs. Stoddart, who has been identified with Army work for the last six years, travels throughout the state, informing the public of the Army's program

to teach persons, especially those of high school and college age, that cancer is curable in its early stages. She called attention to the annual enlistment campaign, and declared that the Army would continue its educational program during the war.

Dane

The April meeting of the Woman's Auxiliary to the Dane County Medical Society was held on April 11 at the home of Mrs. W. A. Mowry, Madison. Mrs. G. S. Stebbins, chairman of the hostess committee, was assisted by Mrs. H. A. Keenan, Stoughton, and Mrs. W. A. Werrell, Mrs. J. S. Supernaw, and Mrs. J. C. Dean, all of Madison.

Miss Ethel Brubaker, superintendent of the Industrial School for Girls at Oregon, was the guest speaker.

Dodge

Members of the Woman's Auxiliary to the Dodge County Medical Society held their March meeting at the home of Mrs. E. C. Hoyer, Beaver Dam. Several philanthropic plans were discussed. After the business meeting the group knitted for the Red Cross and spent a social hour. The group is collecting old playing cards and magazines for distribution among the hospitals of the county.

Kenosha

Meeting at the home of Mrs. C. M. Creswell, Kenosha, on April 7, members of the Woman's Auxiliary to the Kenosha County Medical Society heard the slate of officers for the coming year read by the chairman of the nominating committee, Mrs. Theodore Sokow.

After a report on the activities of the cancer control committee read by Mrs. P. E. Pifer, the group voted a donation to the cancer control fund.

Mrs. C. E. Pechous poured for the tea following the meeting.

La Crosse

Mrs. Adolph Gundersen, La Crosse, was hostess to the Woman's Auxiliary of the La Crosse County Medical Society at a silver tea at her home in April. About seventy-five members and guests were present.

Mrs. K. P. Ruppenthal, Bangor, was a featured soloist, singing the following selections: "Oh, For a Day of Spring" by Andrews, "Mah Lindy Lou" by Strickland, "Hills of Home" by Fox, and "Grandmother Brown" by Gottschalk. She was accompanied by Mrs. H. C. Dowe of Bangor.

A reading on "A Woman in a Shoe Shop" was given by Mrs. H. J. Peters of Bangor.

Doctors' wives from out of town included Mmes. Victor Bruder, Winona; J. R. Richter, Chaseburg; C. M. Strand, Westby; R. L. Alvarez, Galesville; A. A. Solberg, Coon Valley; H. A. Jegi, Galesville; Halbert Gulbrandsen, L. F. Gulbrandsen, R. H. Ludden, R. S. Hirsch, A. E. Kuehn, C. E. Lauder, all of Viroqua.

Assisting at the tea table were Mrs. E. H. Townsend, Miss Fanny Sill and Mrs. F. A. Douglas.

Milwaukee

The annual mother and daughter luncheon of the Woman's Auxiliary to the Medical Society of Milwaukee County was held at the Hotel Pfister, April 10, with ninety-eight members and guests present.

Following the luncheon excerpts from the opera "Sari" by Kalman were presented in costume by members of the Milwaukee Light Opera Company, directed by Mrs. Louis Warfield. Also, Mr. Tom Jacks gave a talk and demonstration on flower arrangements.

Both parts of the program were well received. This was followed by routine business and the reading of the names of nominees for the various offices.

Within the next few weeks, a course in home nursing will be started for members of the Auxiliary. Applications for enrollment are in charge of Mrs. W. A. Joseph and Mrs. N. Warren Bourne.

The refresher course being given by Miss Clara Rue, educational director of the Visiting Nurses Association, meets every Friday morning from 10 to 12. Members of the Auxiliary who are graduate nurses may join this class.

Polk

Dr. and Mrs. K. F. Johnson entertained members of the Polk County Medical Society and its Auxiliary at a dinner in the Methodist Parish Hall, Frederic, on March 19.

The Auxiliary adjourned to the home of Mrs. Johnson for its meeting. Ten members were in attendance. Following the routine business session the Auxiliary was entertained by three young musicians, Miss Inez Erickson, soprano; Miss Mary Laursen, saxophone, and Miss Ruth Laursen, pianist.

A social hour followed. The next meeting will be held in June.

Rock

Six months in Hawaii and Puerto Rico in 1941 provided Mrs. T. F. Shinnick, Beloit, with material for an interesting talk before twenty-five members of Rock County Medical Auxiliary in the Shinnick home, on March 24. A six-thirty dinner preceded the meeting which was conducted by the president, Mrs. C. R. Gilbertsen.

Sauk

Mrs. T. W. Walsh of Sauk City reports that the Woman's Auxiliary to the Sauk County Medical Society met at the home of Mrs. J. F. Moon, Baraboo, on March 26. Nine members were in attendance. A short business meeting was followed by bridge.

Mrs. H. A. Bachhuber, Sauk City, and Mrs. M. F. Huth, Baraboo, assisted the hostess.

Sheboygan

The members of the Woman's Auxiliary to the Sheboygan County Medical Society held a spring luncheon meeting at the home of Mrs. C. M. Yoran, Rocky Knoll Sanatorium, Plymouth, on April 1.

Yellow jonquils in a low bowl centered the dining room table which was set with blue place mats. At the individual card tables, where additional guests were seated, Easter nests and candy were used for decorations.

Assisting Mrs. Yoran as hostesses were Mmes. A. J. Brickbauer, H. F. Deicher and A. C. Radloff, all of Plymouth.

Mrs. T. J. Gunther, Sheboygan, gave an interesting review of the novel, "Dragon Seed," by Pearl S. Buck. Mrs. H. J. Hansen, Sheboygan Falls, presided at the business session.

Washington—Ozaukee

The Washington–Ozaukee County Medical Auxiliary met for dessert bridge at the home of Mrs. A. H. Carthaus, Thiensville, on April 9. Fourteen members and one guest were present. The members from Ozaukee County acted as hostesses.

The reading of a one-act play by Mrs. C. H. Kalb, Grafton, was greatly enjoyed. The winners in bridge were Mmes. Meyer Lynch, West Bend; F. W. Lehman, Hartford, and A. H. Heidner, West Bend.

Society Proceedings

Brown—Kewaunee—Door

There were thirty-five members present at the meeting of the Brown–Kewaunee–Door County Medical Society on April 9 at the Beaumont Hotel, Green Bay. The subject under discussion was coronary disease, the guest speakers being Drs. Robert M. Woods and Louis J. Kurten, both of Milwaukee.

Crawford

The Crawford County Medical Society met on March 26 at Kaber's Kafe, Prairie du Chien. During the business session plans were discussed for emergency medical service throughout the county, as well as the organization of first-aid classes.

Dane

Members of the Dane County Medical Society held a joint meeting with Selective Service workers of the American Legion on March 31. A demonstration was given of the standard technic to be used by all trained first-aid workers during any future emergency.

The regular monthly meeting was held on April 14 at the Dane County Asylum for Chronic Insane, Verona. After a tour of inspection, an informal reception, and dinner, addresses of welcome were given by Mr. William B. Emmerton, superintendent, and Mrs. Mary Garner, member of the board of trustees. The two guest speakers were Dr. Norman A. Levy of Chicago, whose subject was "Medical Attitude Toward County Asylums," and Dr. David A. Cleveland of Milwaukee, whose subject was "Prefrontal Lobotomy."

Dodge

With the headline, "Winter roads are gone; you have a priority on tires; what's to prevent 100 per cent attendance?" Dr. A. G. Hough, secretary of the Dodge County Medical Society, announced the March 26 meeting of his society, at the Rogers Hotel, Beaver Dam. Those present enjoyed an illustrated lecture presented by Dr. Thomas J. Snodgrass of the Pember–Nuzum Clinic, Janesville, entitled "Surgery of the Chest." Dr. Harry Anderson of the River Pines Sanitarium, Stevens Point, assisted in the presentation and discussed the paper.

Eau Claire—Dunn—Pepin

The Eau Claire–Dunn–Pepin County Medical Society met at the Eau Claire Hotel, Eau Claire, on March 30. There were fifty-nine members present. Mr. Charles H. Crownhart, secretary of the State Medical Society, explained the Procurement and Assignment Service. On the medical program there were two Milwaukee speakers. Dr. Edward R. Krumbiegel discussed "The Practice of Public Health Medicine by the Private Physician," and Dr. Joseph M. King discussed "The Treatment of Accidental Wounds."

Fond du Lac

Forty members of the Fond du Lac County Medical Society attended the March 26 meeting of the society, which was held at the Retlaw Hotel, Fond du Lac, commencing with a 6:30 dinner. The guest speaker was Dr. M. G. Peterman, Milwaukee, who discussed "Diagnosis and Treatment of Meningeal Infections in Childhood."

Jefferson

Mr. Charles H. Crownhart, secretary of the State Medical Society, discussed the Procurement and Assignment Service at the meeting of the Jefferson County Medical Society at the Hotel Carlton, Watertown, on April 16. There were twenty-four members present.

Kenosha

At a dinner meeting of the Kenosha County Medical Society at the Elks Club, Kenosha, on April 16, Dr. Maurice A. Hardgrove of Milwaukee discussed "Blood Serum and Blood Plasma." There were seventeen present to hear this interesting paper and to join in the discussion which followed.

La Crosse

There were fifty-one members present at the meeting of the La Crosse County Medical Society on April 14 to hear Dr. M. G. Peterman, Milwaukee, discuss "Pediatric Problems." Also on the program was Mr. Charles H. Crownhart, secretary of the State Medical Society, who explained the Procurement and Assignment Service.

Milwaukee

At the meeting of the Medical Society of Milwaukee County on April 10 at the Milwaukee County Hospital, the following program was presented:

"Castration in Carcinoma of the Prostate," Charles R. Marquardt, M. D., Milwaukee

"Use of Flicker Tests in the Postconcussion Syndrome," Meyer S. Fox, M. D., Milwaukee

"The Application of Modern Principles in the Treatment of Inguinal Hernia," Philip F. Voigt, M. D., Milwaukee

"Masculinity and Femininity," Benjamin A. Ruskin, M. D., Milwaukee

"Complications and Results in the Use of Sulfadiazine From a Review of Over 100 Cases," Kenneth J. Winters, M. D., Milwaukee

The Committee on Postgraduate Education of the Milwaukee Society (Dr. Harry Beckman, chairman) recently announced postgraduate courses in chemical warfare to be presented under the auspices of Marquette University School of Medicine. These lectures, to be presented on six successive Thursdays, began on April 9.

Outagamie

At the meeting of the Outagamie County Medical Society at the Conway Hotel, Appleton, on April 16, the guest speaker was Dr. Victor D. Lespinasse, associate professor of genito-urinary surgery at Northwestern University Medical School, Chicago. His subject was "Tumors of the Urinary Tract Producing Hematuria."

Polk

The regular meeting of the Polk County Medical Society was held on April 16 at Balsam Lake. Dr. R. E. Mutchler, Milwaukee dentist and health adviser for the National Youth Administration, discussed the objectives of the organization and its work in connection with national defense.

Mr. George B. Larson, assistant secretary of the State Medical Society, talked about the work of the Committee on Health and Public Instruction, emphasizing the use of the film strip "Health Achievements in Wisconsin," and the availability of the exhibit on health information paraphrased in nursery rhymes. Mr. Larson also displayed and discussed the medical field unit prepared in accordance with the Emergency Medical Service plans of Civilian Defense. A great deal of interest was evidenced in this unit.

Racine

Dr. John D. Steele of Milwaukee was the guest speaker at the meeting of the Racine County Medical Society on April 16 at the Elks Club, Racine. His subject was "Carcinoma of the Lung."

Rock

At a dinner meeting at the Hotel Hilton, Beloit, on March 24, members of the Rock County Medical Society were addressed by Dr. William F. Braasch, professor of urology at Mayo Foundation, University of Minnesota, and head of the department of urology of the Mayo Clinic, Rochester. Dr. Braasch discussed "Recent Advances in The Treatment of Urinary Tract Infections."

Dr. Harry E. Kasten, Beloit, was program chairman.

Sauk

The Sauk County Medical Society monthly meeting was held at Warren Hotel, Baraboo, on March 26, commencing with a 6:30 dinner. The Procurement and Assignment Service was discussed by Dr. Robert E. Fitzgerald, Milwaukee, and Mr. Charles H. Crownhart, Madison, secretary of the State Medical Society. Twenty-three members were in attendance.

Sheboygan

The regular monthly meeting of the Sheboygan County Medical Society was held at St. Nicholas Hospital, Sheboygan, on March 24. The guest speaker was Dr. Ralph E. Campbell, associate professor of obstetrics and gynecology at the University of Wisconsin Medical School, who spoke on "Carcinoma of the Uterus." Another feature of the program was the showing of a technicolor motion picture on "The Radium Treatment of Cancer of the Cervix Uteri," which was furnished by the Simpson Radium Institute of Chicago.

Twenty-five members were present at this meeting.

Trempealeau—Jackson—Buffalo

When members of the Trempealeau–Jackson–Buffalo County Medical Society met in Galesville on April 16, they were shown a sound film on studies of fertility, by Johnson and Johnson Corporation. Attention was directed to this year's innovation at the meeting of the American Medical Association, the general practitioners' section, and members were urged to advocate its continuance.

Winnebago

The medical profession's part in the war effort was discussed at the April 9 meeting of the Winnebago County Medical Society, which was held at the home of Dr. Ethan B. Pfefferkorn, Oshkosh. Mr. Charles H. Crownhart, secretary of the State Medical Society, and Dr. Stephen E. Gavin, chairman of the State Medical Society Council, explained how the Procurement and Assignment Service is operating to supply the armed services with physicians and at the same time maintain adequate medical care for the civilian population.

Wisconsin Chapter American Gastro-Enterological Association

At the annual meeting Dr. C. J. Corcoran was elected president; Dr. William Ackerman, vice-president, and Dr. F. W. Mackoy, secretary–treasurer.

Subjects presented for discussion at recent round-table meetings follow:

March—"Duodenitis," by Dr. F. W. Mackoy.
April—"Diverticulosis of the Small Intestine," by Dr. M. L. Shutkin.

Milwaukee Neuro-Psychiatric Society

The March meeting of the Milwauke Neuro-Psychiatric Society was held at the Milwaukee County Hospital for Mental Diseases, on the twenty-sixth. An informal reception at Dr. Michael Kasak's residence and a seven o'clock dinner at the hospital cafeteria preceded the scientific program, which included the following speakers:

"Psychoneuroses in the Hospital for Mental Diseases," Samuel Wick, M. D., Wauwatosa

"Porencephaly as a Complication of Cerebral Arteriosclerosis," Opie R. Holloway, M. D., Wauwatosa

"Identical Bilateral Subacetabular Hip Fractures as an Unusual Complication of Metrazol Therapy," Arthur A. Unger, M. D., Wauwatosa

"Prefrontal Lobotomy" (Motion pictures of the operation), David A. Cleveland, M. D., Milwaukee, and Harold T. Schroeder, M. D., Wauwatosa

Milwaukee Oto-Ophthalmic Society

A motion picture program was presented at the dinner meeting of the Milwaukee Oto-Ophthalmic Society at the University Club on April 14. After an introduction by Mr. John Walch, representative of the Wisconsin Telephone Company, the following films were shown: "The Voice That Science Made," "Life Begins Again," and "A Modern Aladdin's Lamp."

FACILITIES FOR TREATMENT OF POLIOMYELITIS

The Wisconsin Orthopedic Hospital announces that beginning June 1 facilities will be available for the treatment of acute cases of anterior poliomyelitis and that physicians, who so desire, may refer cases for treatment just as soon as the diagnosis is established rather than waiting as heretofore until after the quarantine period has ended. A limited number of beds, for children only, in a section of the hospital in which this contagious disease technic prevails, will be available.

News Items and Personals

PAUL A. BREHM, M. D.

Dr. Paul A. Brehm of Madison, supervisor of the Industrial Hygiene Unit of the State Board of Health, spoke before a group of public health and industrial nurses at a conference held in Green Bay on March 19. His subject was "Health Hazards in Industry."

At the meeting of the Milwaukee district of the Wisconsin State Nurses' Association in Milwaukee on April 6, *Dr. Brehm* discussed "The Developments of Industrial Nursing Service in Our War Effort."

On April 11, at a conference held in Washington, D. C., *Dr. Brehm* was named vice-chairman of the National Conference of Governmental Industrial Hygienists.

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Members of the State Medical Society who participated in the meeting of the American College of Physicians in St. Paul, Minnesota, from April 20 to 24, are as follows:

Edgar S. Gordon, M. D., Madison, "Diseases of Metabolism."

Chester M. Kurtz, M. D., Madison, "Rheumatic Heart Disease."

Ovid O. Meyer, M. D., Madison, "Diseases of Lymph Nodes."

William H. Oatway, M. D., Madison, "Pulmonary Diseases: Fungi and Tuberculosis."

Karver L. Puestow, M. D., Madison, "Cardiospasm and Related Conditions."

Elmer L. Sevringhaus, M. D., Madison, "The Female Hormones," "Practical Uses of Endocrine Substances," "Obesity and Menstrual Irregularity."

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Six Wisconsin physicians were inducted into fellowship in the American College of Physicians. They are *Drs. Joseph J. Furlong*, Milwaukee; *Maurice A. Hardgrove*, Milwaukee; *William M. Jermain*, Milwaukee; *Thomas O. Nuzum*, Janesville; *Oscar A. Sander*, Milwaukee, and *John A. Schindler*, Monroe.

Among associates elected were the following two Wisconsin physicians: *Drs. Howard J. Lee*, Oshkosh, and *Lamont R. Schweiger*, Shorewood.

Dr. Michael W. Shutkin, Milwaukee, was certified by the American Board of Gastro-Enterology at their last meeting in Minneapolis, Minnesota, on April 18. This is in addition to certification by the American Board of Internal Medicine in February, 1941.

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Dr. Samuel B. Pessin, Madison, spoke on April 7 at the meeting of the Madison Society of Medical Technologists at St. Mary's Hospital. His subject was "Histoplasmosis capsulatum (Darling's disease)," and he demonstrated lantern slides and cultures of the fungus.

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It was recently announced that *Dr. Walter M. Kearns*, Milwaukee urologist, has been elected to fellowship in the International College of Surgeons, Geneva, Switzerland.

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Dr. Armond J. Quick of Milwaukee, editor of *The Journal's* page entitled "Comments on Treatment," addressed the Academy of Medicine of Kansas City on April 17. His title was "Hemostasis." On the same day he also appeared before the student body of the University of Kansas Medical School to discuss "The Clinical Significance of Liver Function Tests."

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Dr. Milton Trautmann, director of the Division of Venereal Diseases of the State Board of Health, addressed the Prairie du Sac Red Cross nursing class on April 20. His subject was cancer and its prevention, and the general public was invited to attend.

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The common council of Milwaukee recently confirmed the reappointment of *Dr. Edward R. Krumbiegel*, health commissioner. *Dr. Krumbiegel*, whose new term is to be four years, immediately announced the reappointment of *Dr. Gerald F. Burgardt*, deputy health commissioner.

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Walter J. Meek, Ph. D., assistant dean and professor of physiology of the University of Wisconsin Medical School, is acting as dean of the school in the absence of *Dr. William S. Middleton*, who recently entered the army as a lieutenant colonel. *Dr. Meek* is an honorary member of the State Medical Society.

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Drs. M. Meredith Baumgartner and *Evert C. Hartman*, both of Janesville, spoke before the Lions Club of that city on April 21. The subject under discussion was the development of insulin and its uses in treating diabetic patients.

When the Second American Congress on Obstetrics and Gynecology met in St. Louis, April 6 to 10, the following members of the State Medical Society were present: *Drs. Ralph E. Campbell,* Madison; *Arthur A. Cantwell,* Shawano; *Clarence H. Falstad,* Eau Claire; *Francis M. Frechette,* Janesville; *Joseph M. Freeman,* Wausau; *Carl S. Harper,* Madison; *Edwin P. Hayes,* Eau Claire; *Malcolm M. Hipke,* Milwaukee; *Willard G. Huibregtse,* Sheboygan; *William C. Keettel, Jr.,* Madison; *George S. Kilkenny,* Milwaukee; *Randolph W. Kreul,* Racine; *Thomas A. Leonard,* Madison; *Albert M. Lindner,* Racine; *Carl D. Neidhold,* Appleton; *Roland J. Schacht,* Racine; *Edwin J. Schneller,* Racine; *Addie M. Schwittay,* Madison; *George H. Stevens,* Wausau; *George W. Walter,* Racine; *John D. Wilkinson,* Oconomowoc, and *Roland S. Cron,* Milwaukee.

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Places on the national health honor roll for 1941 were won by Milwaukee, Madison, and Racine, the United States Chamber of Commerce, sponsor of the city health conservation contest, recently announced. Eleven other cities and fourteen counties in seventeen states were named on the honor roll, but no other state had as many winning cities as Wisconsin. It is the fifth time that Milwaukee has been honored for health achievement in the contest.

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Dr. E. F. Schneiders, Madison, was the guest speaker on April 15 at a county-wide meeting at Kohler, sponsored by the Women's Field Army of the American Society for the Control of Cancer. In the course of *Dr. Schneiders'* discussion of "The Hopeful Aspects of Cancer," he remarked that "Cancer is a personal problem and depends upon the cooperation of the patient and the physician."

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Dr. John E. Martineau, Elkhart Lake, addressed the Study Club of that village on the "Milestones of Progress in Medicine the Last 100 Years," at a meeting on April 6. He discussed the beginning of organic chemistry, preventive medicine, surgery, radiology, conquest of pernicious anemia, and new concepts in the treatment of disease, the sulfa drugs.

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Dr. Everett L. Mason, Eau Claire, addressed the Chippewa Valley Underwriters at their monthly meeting on April 10, discussing his observations of life insurance from the viewpoint of a policyholder and a medical examiner.

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"Cancer in its early stages—and every cancer has an early stage—is curable," *Dr. W. D. Stovall,* state chairman of the American Society for the Control of Cancer, told Rotarians, physicians, nurses, dentists, and representatives of various civic organizations at a recent luncheon meeting at the Valley Inn, Neenah. "Cancer," he said, "is not a new disease for it was known to exist some 400 years before the time of Christ."

Dr. Allan A. Filek, Green Bay, spoke on "City Health" at the Vocational School in that city on March 24. He also led an open forum discussion.

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Dr. Frederick P. Knauf, Kiel, has been appointed city health officer to fill the vacancy caused by the resignation of the late Dr. George Mathes, shortly before his death.

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Dr. Arthur J. Williams, Waukesha, has been appointed physician and surgeon at the Wisconsin Industrial School, Waukesha.

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Dr. Fred A. Nause, Sheboygan, was the guest speaker at the meeting on April 8 of the Catholic Women's Charity Club, Sheboygan. The subject under discussion was medical care as it is supplied both in the United States and in foreign countries.

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Dr. Friedrich Eigenberger, Sheboygan pathologist, addressed students of the Mayville High School on April 17 on the subject of cancer, his title being "Fighting Cancer With Knowledge." The public was invited to the meeting.

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Dr. Frederick G. Jensen, Menasha, addressed members of the Menasha unit of the Women's Field Army of the American Society for the Control of Cancer, at a meeting held in the auditorium of the Elisha D. Smith Library on March 24.

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Dr. William S. Middleton, dean and professor of medicine of the University of Wisconsin Medical School, addressed the members of the Hennepin County Medical Society in Minneapolis on April 6. The title of his address was "Some Rationalized Therapeutic Experiences." He also participated in the postgraduate course on internal medicine presented at the University of Minnesota Center for Continuation Study during the period of April 6 to 18.

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Dr. Errol V. Brumbaugh, former Milwaukee deputy health commissioner, has been appointed health commissioner of West Allis. He assumes the position vacated on February 14 by the resignation of *Dr. Frank H. Russell.*

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Dr. Roger C. Cantwell, Shawano, was the speaker at the meeting of the Clintonville Rotary Club on March 30. He discussed the effects of worry and its permanent injury to the health of the worrier.

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At the meeting of the Workman's Circle on March 28, *Dr. George J. Juckem,* Sheboygan, spoke on Pearl Harbor and the medical corps of the U. S. Army.

Dr. Gwilym E. Davies, of Waukesha, addressed the class in tropical medicine at Marquette University School of Medicine, on March 21. His talk, which was on medical practice in the African tropics, was illustrated with colored motion pictures taken while he was surgeon to the Presbyterian Mission Hospital and Medical School in French Cameroun, West Africa.

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Dr. Thaddeus D. Smith, Neenah, in addressing members of the Neenah Rotary Club at the Valley Inn on March 19, stated "This is a total war and a gigantic undertaking. We must mobilize men, machines, and all resources." He discussed the part the medical profession is playing in the present conflict, the use of human blood and plasma in the treatment of disease, and the development of the science of blood transfusion.

SOCIETY RECORDS

New Members

W. B. A. J. Bauer, Ladysmith.

A. P. Schoenenberger, Denmark.

W. L. Cochrane, Wayside.

Lois Lobbs, 303½ South Barstow Street, Eau Claire.

A. L. Cramp, Gilman.

P. A. Brehm, State Board of Health, Madison.

Elgie Kraut, Lancaster.

P. S. Herzog, U. S. National Bank Building, Kenosha.

H. A. Aageson, Main Street, Oconto.

L. C. Dietsch, Plymouth.

J. C. Baker, Hawkins.

M. A. Borchardt, New London.

A. A. Unger, 8844 Watertown Plank Road, Milwaukee.

W. J. Schacht, 425 East Wisconsin Avenue, Milwaukee.

S. G. Weisfeld, 716 North Eleventh Street, Milwaukee.

W. A. Langmack, 308 West North Avenue, Milwaukee.

L. R. Schweiger, 425 East Wisconsin Avenue, Milwaukee.

P. W. Ryan, 3405 West Lisbon Avenue, Milwaukee.

R. H. Jones, Ripon.

H. T. Callahan, Spencer.

W. H. Schuler, Fennimore.

A. V. Cadden, Muirdale Sanatorium, Wauwatosa.

Manfred Landsberg, 4747 South Packard Avenue, Cudahy.

E. F. Carl, 606 West Wisconsin Avenue, Milwaukee.

E. C. Schmidt, 6227 West Greenfield Avenue, Milwaukee.

A. W. Peelen, 2248 South Kinnickinnic Avenue, Milwaukee.

H. R. Brukardt, 135 West Wells Street, Milwaukee.

W. G. Winter, 1018 North Jefferson Street, Milwaukee.

H. P. Robinson, 2200 North Third Street, Milwaukee.

Alfred Beutler, 238 West Wisconsin Avenue, Milwaukee.

Abraham Melamed, 908 North Twelfth Street, Milwaukee.

Changes in Address

T. H. Joyner, Mt. Horeb, to Oregon.

J. M. Fraser, Oshkosh, to 505 West Elm Street, Enid, Okla.

C. L. Newberry, Milwaukee, to 17 Brief Avenue, Upper Darby, Pa.

R. J. Brown, Cazenovia, to Wonewoc.

R. V. Kuhn, Watertown, to 95 Oakland Avenue, Oshkosh.

J. M. Rose, Marinette, to Wausaukee.

G. V. Hough, Milwaukee, to Marathon County Health Unit, Wausau.

C. Zimmermann, Milwaukee, to Oakwood Manor, 547 Cherry Street, Grand Rapids, Mich.

BIRTHS

A daughter, Harlynn Ruth, to Dr. and Mrs. Norman N. Fein, Mare Island Hospital, San Francisco, on April 21.

A daughter, Ruth Tore, to Dr. and Mrs. Thorolf E. Gundersen, La Crosse, on March 9.

Twin sons, Richard Perry and Bruce Perry, to Dr. and Mrs. Perry T. Walters, La Crosse, on March 12.

MARRIAGES

Dr. Edward G. Schott and Miss Barbara Allman, both of Sheboygan, on March 28, at Sheboygan.

Dr. Gunnar D. Quisling, Camp Stewart, Georgia, and Miss Helen Anderson, Madison, on March 29, at Camp Stewart, Georgia.

DEATHS

Dr. John E. Barnstein, Manitowoc physician, died at his home on April 20. Upon his retirement a few weeks ago he was the oldest practicing physician in the county and one of the oldest in Wisconsin.

Dr. Barnstein was born in Newton, Wisconsin, in 1852, and received his early education from the Mission House College, Franklin, Sheboygan County. Thereafter he taught school in Sheboygan and Manitowoc counties, but after several years he turned his attention to medicine, registering as a pharmacist and establishing a drug store in Manitowoc. Continuing his studies, he received his M. D. degree from Milwaukee Medical College in 1896. He also took postgraduate work in Chicago in the field of eye, ear, nose, and throat.

Dr. Barnstein formerly held membership in the Manitowoc County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are a son, Fred W. Barnstein, Manitowoc optometrist; four daughters, Mrs. Edward Pasewalk of Manitowoc, Mrs. William Altman of Sheboygan, Mrs. Henry Zenk of Eureka, South Dakota, Mrs. Arthur Achtemeier of Monticello; twelve grandchildren and five great-grandchildren.

Dr. Henry C. Krohn, who had served as health officer of New Holstein for twenty-four years, died on April 15 in a Sheboygan hospital.

He was born in 1882 near Cedarburg, and attended school there and in Thiensville. After his graduation from Oshkosh Normal School, he served as school superintendent at Merrill until 1910 when he entered Milwaukee Medical College. He received his M. D. degree in 1914.

Dr. Krohn was a member of the Calumet County Medical Society, State Medical Society of Wisconsin, American Medical Association, and Alpha Kappa Kappa, medical fraternity of Marquette University School of Medicine.

Dr. John T. Lemmel, Beloit, died on April 14 at a Beloit hospital following a heart attack.

He was born in 1882 at Evansville, Wisconsin, and attended the Evansville Seminary. He completed his medical education at the University of Illinois College of Medicine in 1907. In 1909 he established a practice at Albany, and he remained there until 1930 when he moved to Beloit. Dr. Lemmel was active in civic affairs in both Albany and Beloit, and formerly was a member of the Rock County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow; a daughter, Patricia, Madison; and a brother, Paul T., a niece, and a nephew, all of Madison.

Dr. Clyde W. Morter, well-known Milwaukee physician, died on April 11 at a Milwaukee hospital after a week's illness.

After graduation from the Lodi high school, he and his brother, Ralph E., entered the Wisconsin College of Physicians and Surgeons, Milwaukee, from which they were graduated in 1907. They immediately established themselves in Milwaukee in a partnership for the practice of their profession.

Dr. Morter, a member of the staffs of Columbia Hospital, Milwaukee County Hospital and Dispensary, and Mount Sinai Hospital, was assistant clinical professor of proctology at Marquette University School of Medicine. He was also a consulting proctologist at the Veterans Administration Facility.

Dr. Morter was a member of the Medical Society of Milwaukee County, State Medical Society of Wisconsin, American Medical Association, Milwaukee Academy of Medicine, American Proctological Society, and American Board of Surgery.

Surviving him are his widow; a son, Howard; a daughter, Mrs. Royal Hayes; two brothers, Raymond and Dr. Ralph E., and his father.

Dr. Ronald B. Rogers, prominent Neenah physician and surgeon and a veteran of World War I, died on April 4 at an Oshkosh hospital following a three weeks' illness.

He was born in Racine in 1891, and after completing the course in the elementary schools, attended Phillip–Exeter Academy, Exeter, N. H., before entering Columbia University College of Physicians and Surgeons, from which he received his M. D. degree in 1917. He served his internship in the French Hospital, New York City, until December of that year when he enlisted in the United States Navy. He was ship's surgeon, with the rank of senior grade lieutenant, on the U. S. S. De Kalb, and was honorably discharged from the service in October, 1919. Dr. Rogers then served on the staff of Lenox Hill Hospital, New York City, before coming to Neenah in 1921. A member of the first medical staff of Theda Clark Memorial Hospital, at the time of his death he was president of the staff.

Dr. Rogers was a member of the Winnebago County Medical Society, State Medical Society of Wisconsin, and Association of Military Surgeons of the United States of America, and a fellow of the American Medical Association.

Surviving him are his widow; a daughter, Doris Isabel; a son, Ronald B., Jr., and his mother, Mrs. Orrin Johnson, all of Neenah.

Dr. Alfred L. Suhr, Milwaukee, a member of the Milwaukee County Hospital staff, died on April 8 at a Milwaukee hospital. He was born in 1899 in Milwaukee. After graduation from North Division high school, he attended the University of Wisconsin and Marquette University School of Medicine, from which he received his M. D. degree in 1927.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow; his mother, Mrs. Mary Suhr; a sister, Mrs. William Schuelke, and a brother, Ernest.

VICE-PRESIDENT OF UPJOHN FIRM DIES

Malcolm Galbraith, vice-president and director of sales of the Upjohn Company, died on April 10 in Kansas City.

Mr. Galbraith was born in Bowmanville, Ontario, in 1876. He received his bachelor of pharmacy degree at Ontario College of Pharmacy in 1898, entering in the drug business in the same year. He later became a naturalized citizen of the United States, and in 1909 joined the Upjohn Company. In 1929 he was elected to the board of directors and named director of sales. He was made vice-president of the company in 1936.

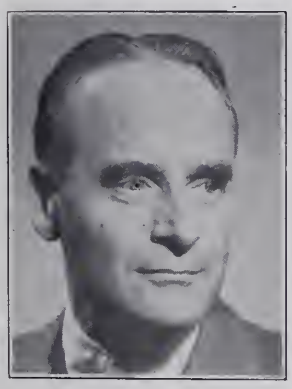
Scientific Program For One Hundred First Anniversary Meeting Announced by Council on Scientific Work

September 14, 15, and 16, Milwaukee Auditorium

THE Council on Scientific Work of the State Medical Society of Wisconsin appointed Dr. E. R. Schmidt of Madison as program chairman for the One Hundred First Anniversary Meeting. Dr. Schmidt has completed arrangements for the general program and secured acceptances from the speakers selected to present the papers chosen by him and approved by the Council on Scientific Work.

The programs of the various sections, which were prepared by section chairmen, are also complete. The chairmen are: *Obstetrics and Gynecology*—Dr. Francis M. Frechette, Janesville; *Surgery*—Dr. Albert R. Tormey, Madison; *Medicine*—Dr. Gjermund Hoyme, Eau Claire; *Ophthalmology and Otolaryngology*—Dr. Reinhold O. Ebert, Oshkosh; *Pediatrics*—Dr. Francis R. Janney, Milwaukee; *Urology*—Dr. Alf H. Gundersen, La Crosse; *Cardiology*—Dr. Chester M. Kurtz, Milwaukee, and *Orthopedics*—Drs. Chester C. Schneider and Walter P. Blount, both of Milwaukee.

Special Attraction



H. KENT TENNEY, M. D.

A feature which will attract wide attention during the opening and closing hour of each day's session is a special program assigned by the Council on Scientific Work to Dr. H. Kent Tenney of Madison. Motion pictures describing scientific subjects of current interest will be shown, and a large number of films are being viewed by Dr. Tenney in order to select those of unquestioned merit.

Exhibits

The scientific exhibits, under the direction of Dr. C. J. Smiles of Ashland, are in the course of selection, and an announcement concerning their nature will appear in an early issue of this *Journal*.

The entire main arena is reserved for the scientific and technical exhibits, as well as the hobby show. Anticipating an increased demand for technical exhibit booths this year, additional space was made available, but within a few days after the release of the information on the exhibit hall layout, exhibitors had reserved all available space.

Hobby Show

Requests for reservation of exhibit space at the Physicians' Hobby Show to be presented in conjunction with the One Hundred First Anniversary Meeting of the State Medical Society continue to be received by Dr. C. J. Smiles, director of scientific exhibits and the hobby show.

Arrangements have been made to place an extensive stamp collection of Dr. J. J. Barrock, Milwaukee, in special show cases and display areas. Colored kodachrome slides belonging to Dr. M. G. Peterman, Milwaukee, will be shown. These are in addition to other outstanding exhibits such as Dr. R. G. Arveson's (Frederic) display of bells, and Dr. H. J. Lee's (Oshkosh) collection of outstanding photographs of water fowl. It is hoped that there will be presented also a display of hand-manufactured clocks.

Your reservation blank appears on page 430.

Spring Clinics in Chippewa Falls, Wausau, and Fond du Lac Are Well Attended

OVER 400 Wisconsin physicians attended the Society's Annual Spring Clinics in Chippewa Falls, Wausau, and Fond du Lac, on April 27, 28, and 29, respectively. The varied program attracted physicians from a wide area surrounding each of the clinic centers, a number of physicians traveling over a hundred miles to be present. The members of the Council on Scientific Work are commended for their efforts in developing such an outstanding program and making it available to communities in the northern and central parts of the state.

"Among the Topics Discussed . . ."

So attractive was the program that 95 per cent of those registering for the initial paper in the morning remained until the conclusion of the round-table sessions in the evening. While these round tables were the high light of the program, another feature of interest was the obstetrical manikin demonstration by Dr. W. C. Keettel, instructor in the Bureau of Maternal and Child Health of the State Board of Health.

The scientific program arranged by Dr. G. W. Krahn of Oconto Falls had a planned continuity and provided a brief refresher course on the anatomy of the areas of the body under discussion. This feature was presented by Walter Zeit, Ph. D., assistant professor of anatomy, Marquette University School of Medicine.

The portable x-ray unit of the State Board of Health attracted wide attention, and many members of the Society availed themselves of the opportunity of having a 35 mm. x-ray picture taken of the chest.

"Management of Peptic Ulcer . . ."

Among the topics discussed was surgical management of peptic ulcer. "There is general agreement that ulcers should be treated medically, except when certain complications occur, or when there is no response to intelligent medical treatment," said Dr. F. A. Stratton, clinical professor of surgery at Marquette University School of Medicine. "There has been in the last two decades," he continued, "a marked change in the attitude of surgeons and internists regarding the treatment of ulcers. To select the type of operation requires judgment based on wide experience."

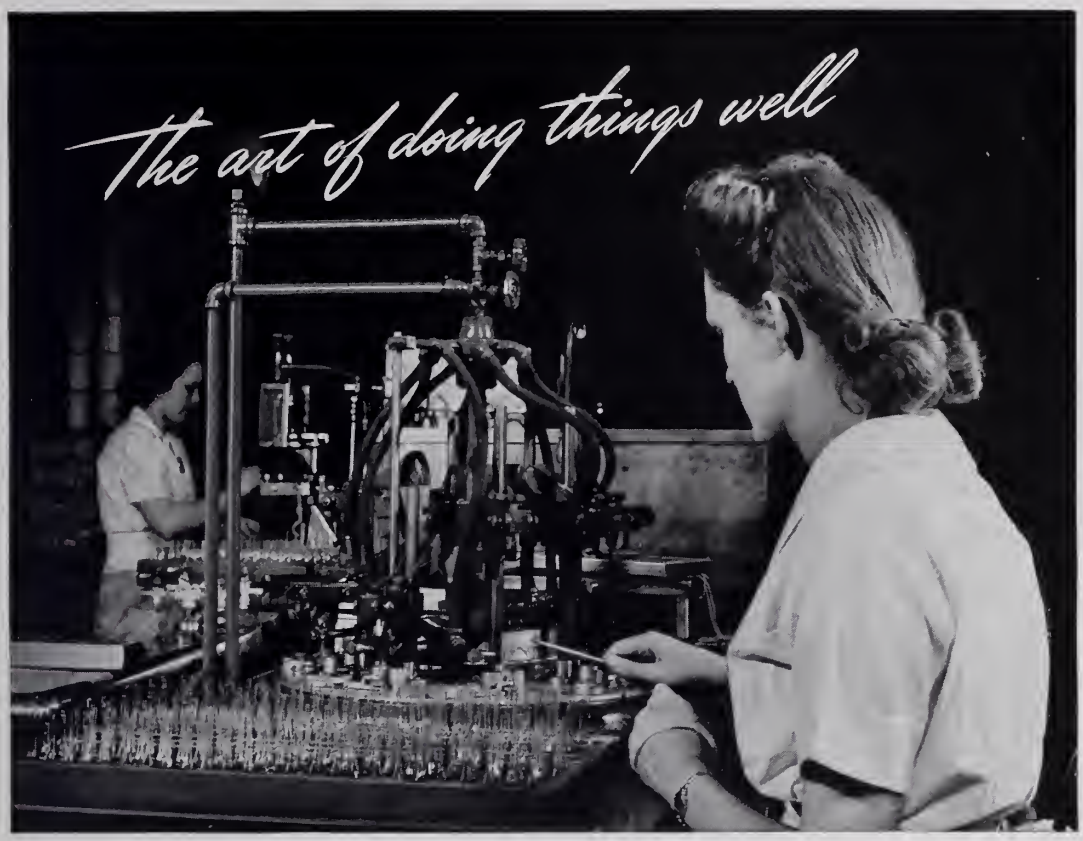
"It is of the utmost importance," declared Dr. W. L. Palmer, associate professor of medicine at the University of Chicago School of Medicine, "to locate the ulcer precisely by the use of roentgenograms. Thereby it becomes possible to determine not only the size of the crater but also the degree of stenosis and the response of the crater to treatment." Later in his address Dr. Palmer emphasized "that the relief of symptoms alone is not an adequate criterion of successful therapy. In the medical treatment of peptic ulcers, the therapy should be based primarily upon the time-honored concepts of rest, a bland diet, and an acid neutralizing regimen."

"No Pearl Harbor . . ."

In discussing the relationship of the war to the medical profession, Chairman Gavin stressed the continuing obligation in the field of scientific medicine in the interchange of professional knowledge. Directing attention to the necessity of protecting the health of the nation, Dr. Gavin declared, "Those who serve the armed forces of our country and our war objectives by remaining at home to engage in vital industries or vital activities, are as important to our national life at the home front as those at the front lines."

Emphasizing that months ago the medical profession was determined that there should be no Pearl Harbor in its ranks, Dr. Gavin pointed out that the Procurement and Assignment Service for Physicians, Dentists and Veterinarians was created by order of the President at the specific request of the medical profession. Noting that it served

(Continued on page 428)



IT MAY TAKE years of experience to find the best way to do a thing. Take the problem of sealing ampoules, for instance. That's a job that can be done very well by hand, but it's slow work when every ampoule must be handled individually. The machine way is best. Production steps up when steel fingers are set to molding the smooth tips of heat-softened glass. Quality is better, too, for ampoules sealed mechanically rarely have charred tips and black floaters to plague the inspectors. Lilly Ampoules provide fine medication in finest glass enclosures.

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two fundamental purposes, that of protecting the community health by passing upon the availability of physicians for service in the light of community need, and that of supplying the armed forces with physicians possessing the qualifications required, Dr. Gavin declared, "The Procurement and Assignment Service represents one of the most important contributions of the medical profession to a nation at war. Enrolment with Procurement and Assignment Service indicates the professional man's willingness to serve his country in the way in which he may be best fitted, whether at home, in industry or in one of the many branches of government service available in wartime.

"Through the agency of Procurement and Assignment, assurance is given that those determined essential to the community needs will be retained, while those who can be spared from the community will be made available to the armed service.

"I am convinced that the medical profession in Wisconsin, as elsewhere, will recognize its obligation in this crisis, as it has in every national crisis in the past, and that when these days of national emergency are over, Procurement and Assignment Service will stand as a monument to a profession that is prepared and responsive to its country's needs."

KEETTEL—200 DEATHS ASSOCIATED WITH CESAREAN SECTION—1934-1940

(Continued from page 400)

not know all the circumstances surrounding each case, so we must be very careful in drawing any conclusions. Nevertheless, in this group of 200 women who died, we know there were a certain number in whom definite contraindications for section were disregarded. These may be summarized as follows:

1. Sixty women in labor over six hours, many of whom had ruptured membranes, preceding vaginal examinations, and in 13 instances attempts at delivery from below, were delivered by classical cesarean section.

2. Thirty-one patients with eclampsia as the sole operative indication were delivered by cesarean section.

3. Twenty-five patients with toxemia, in whom this was the sole indication, were delivered by cesarean section. There was no mention made that these were the fulminating type of pre-eclamptics.

4. Five patients had hydrocephalic or badly macerated babies, yet were delivered by cesarean section, despite no mention of any pelvic indication.

5. Five patients either had a prolapsed cord, or the patient or family wanted a section performed.

6. Four patients had low cervical sections although the labor was prolonged and there had been attempts at delivery from below.

It would appear from this analysis of 200 deaths associated with cesarean section that 117 women (7 appeared twice), or 58.5 per cent, were delivered by cesarean section in spite of contraindications. Some of these patients undoubtedly would have survived if there had been delivery from below, or if a different type of cesarean section had been chosen.

If we are to continue our improvement in maternal care, the reduction in the number of cesarean section deaths will be an important factor. We can do this if we will keep certain facts in mind:

1. Cesarean section is still a dangerous operative procedure, carrying a much higher mortality than delivery from below, therefore we must evaluate each patient wisely.

2. Emergency sections carry a higher mortality than a purely elective section. Every effort should be made to eliminate as nearly as possible the emergency section.

3. We should have a very clear understanding of the different types of sections, their indications and limitations.

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Application Blank, Physicians' Hobby Show

One Hundred First Anniversary Meeting

Milwaukee Auditorium, September 14, 15 and 16

Tear out this application blank for the purpose of reserving exhibit space at the Physicians' Hobby Show to be presented in the exhibit hall of the main arena of the Milwaukee Auditorium.

Acceptable exhibits include photographs, sketches, wood working, wood carving, stamp collections, metal spinning and similar hobbies.

Indicate with an X, in the list of subjects below, the hobby which you wish to exhibit, and mail your application at once to Dr. Smiles at the address given.

C. J. Smiles, M. D., Director of Scientific Exhibits
State Medical Society of Wisconsin
917 Tenney Building, Madison, Wisconsin
Dear Dr. Smiles:

I wish to make application for exhibit space at the Physicians' Hobby Show to be presented in connection with the One Hundred First Anniversary Meeting of the State Medical Society of Wisconsin.

My hobby exhibit will require _____ lineal feet of space (six feet high).

My exhibit will be on the following subject (subjects):

Bells _____	Paintings _____
Books _____	Prescriptions _____
Clay modeling _____	Sculpture _____
Coins _____	Sketches _____
Dishes _____	Soap carving _____
Documents _____	Stamps _____
Etchings _____	"Still" photographs _____
Firearms _____	Surgical instruments _____
Floriculture _____	Swords and knives _____
Glassware and glass blowing _____	Taxidermy _____
Jewelry _____	Weaving _____
Manuscripts _____	Wood carving _____
Match covers _____	Wood working _____
Metal spinning _____	_____
Metal working _____	_____
Model railroads _____	_____
Motion pictures _____	NAME: _____
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HART—(INTERVIEW)—MILK IN NATIONAL HEALTH

(Continued from page 406)

Energy Comes in the Milk Bottle

As a source of caloric energy, milk is very satisfactory. A quart of 4 per cent milk supplies a little less than 700 calories. The daily requirement for an adult varies from 2,500 to 6,000, depending on the season of the year and the energy expended in daily work. Thus milk can help in filling the energy requirements, and may also be employed to help regulate the caloric intake.

Incidentally, milk may be advantageously used in the reducing diet, supplemented by fruit juices, salads, and auxiliary sources of copper, iron, and manganese.

Pasteurization carried on by the newer processes has little effect on the nutritive value of milk. Some earlier methods partially destroyed the vitamin C and thiamin, but methods are being initiated to retain those vitamins. And even when there are minor losses of those two substances, milk remains an excellent protective and health-promoting food.

Some Figures on Food Needs

In final summary, Hart explains that milk in liberal quantities is a desirable addition to any daily food plan.

Here's the share of the nutrients an average man requires which can be supplied by a daily quart of milk:

Vitamin A	35 per cent
Vitamin D	10 per cent
Vitamin C	35 per cent
Thiamin	15 per cent
Nicotinic acid	20 per cent
Riboflavin	A full supply
Calcium	More than enough
Phosphorus	65 per cent
Protein	Almost half
Caloric energy	12 to 20 per cent

With that tabulation in mind, it takes no profound rationalization to explain why milk has always held a place as the first food in the human diet.

COMING EVENTS

University of Wisconsin Medical School Schedule of Saturday Morning Clinics

May 16. Pediatrics: Manifestations of Tuberculosis in Infancy and Early Childhood. Dr. McDonough and Associates

May 23. Surgery: Fractures of the Back from a Neurosurgeon's Viewpoint. Dr. T. C. Erickson

May 30. Medicine: Clinical Avitaminosis. Dr. Gordon and Associates

—△—

Milwaukee Children's Hospital—Schedule of Clinical Presentations

12:30—1:30 p.m.

May

Pediatric Clinic, Friday, May 15
Presentation of Interesting Cases.

Pediatric Clinic, Friday, May 22
Presentation of Interesting Cases.

—△—

Examinations—American Board of Obstetrics and Gynecology

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted at Atlantic City, N. J., by the entire Board, from Thursday, June 4, through Tuesday, June 9, 1942, prior to the opening of the annual meeting of the American Medical Association.

Group A, Part II, candidates will be scheduled for examination the first part of the examination period, and Group B, Part II, the latter half. Formal notice of the time and place of these examinations will be sent each candidate several weeks in advance of the examination dates.

Candidates for *reexamination* in Part II must make written application to the secretary's office before April 15, 1942.

(Continued on page 434)

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As previously announced in the Board booklet, this fiscal year (1941–1942) of the Board marks the close of the two groups of classification of applicants for examination. Thereafter, the Board will have only one classification of candidates, and all will be required to take the Part I and Part II examinations.

The Board requests that all prospective candidates who plan to submit applications in the near future request and use the new application form which has this year been inaugurated by the Board. The secretary will be glad to furnish these forms upon request, together with information regarding Board requirements. Address Dr. Paul Titus, secretary, 1015 Highland Building, Pittsburgh, Pennsylvania.

—△—

Wisconsin Trudeau Society

The next meeting of the Wisconsin Trudeau Society will be held on June 12 and 13 at the Four Seasons Club near Pemb'ne, Wisconsin. The meeting will be combined with that of the Michigan Trudeau Society.

Membership in the Wisconsin Trudeau Society is open to all physicians interested in chest diseases. Any physician can have his name included on the mailing list by sending $1 to the secretary-treasurer, Dr. J. D. Steele, 324 East Wisconsin Avenue, Milwaukee. Dues are used to defray expenses of guest speakers and mailing and are collected only when the treasury becomes depleted (as it is at the present time).

—△—

Postgraduate Course in Chemical Welfare

By Dr. J. C. Troxel, Lieutenant, Medical Corps, United States Navy

Graduate Chemical Warfare Course, Navy Medical School, Washington, D. C.

Beginning: Thursday, April 9, 1942, 8:30 p.m. Six lectures on six successive Thursdays.

At: Marquette University School of Medicine Auditorium, 561 North Fifteenth Street, Milwaukee, Wisconsin.

For: (1) Students of Marquette University School of Medicine and (2) Members of the Medical Society of Milwaukee County.

Students attending all lectures and passing an examination at the end of the course will be given academic credit, which will be of value for future military or civilian services.

Wisconsin Society of Obstetrics and Gynecology

Friday, May 15, Loraine Hotel, Madison

The program will consist of a scientific session in the morning, beginning at nine o'clock, and a business meeting in the afternoon with luncheon at the hotel.

Dr. Lawrence M. Randall of the Mayo Clinic will be the guest speaker, and other papers will be presented by members of the Society.

—△—

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Two Weeks—August 17–August 29, 1942

By Dr. Louis N. Katz
Director of Cardiovascular Research

—△—

The American Congress of Physical Therapy

Will hold its twenty-first annual scientific and clinical session September 9, 10, 11 and 12, 1942 inclusive, at the Hotel William Penn, Pittsburgh, Pennsylvania. The annual instruction course will be held from 8 to 10:30 a. m., and from 1 to 2 p. m. during the days of September 9, 10 and 11 and will include a round-table discussion group from 9 to 10:30 a. m., Thursday, September 10. The scientific and clinical sessions will be given on the remaining portions of these days and Saturday morning. A new feature will be an hour demonstration showing technic, from 5 to 6 p. m. during the days of September 9, 10 and 11. All of these sessions and the seminar will be open to the members of the regular medical profession and their qualified aids. For information concerning the seminar and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.

PHYSICIANS' HOBBY SHOW

Have you developed a hobby for recreation? Would you like to exhibit it at the Physicians' Hobby Show? For details and application blank, see pages 425 and 430.

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WEAR, KOHLER—CANCER OF BLADDER

(Continued from page 394)

marked infiltration of the muscular tissue. This man is alive and well seven years later, without recurrence.

Previous to the advent of transurethral resection by the loop method, the larger percentage of patients was subjected to open operation. If the growth was found in a region where segmental resection was possible, it was removed, but we can expect this only in about 10 per cent of cases. When the lesion was located in the trigone, where the larger percentage do occur, fulguration was employed and perhaps radium emanation needles were inserted around the growth, followed by x-ray therapy if the operator had faith in it. Today transurethral resection and fulguration have supplanted the open operation, with less debilitating results and considerable lowering of the mortality rate.

In my experience, x-ray therapy has been discouraging, but one cannot discard it completely. Recently a method was advocated for the application of x-ray therapy to the open bladder. This gives promise of better results, although it is too early to make definite claims. Total cystectomy after bilateral transplantation of the ureters has been done by a number of surgeons with fairly reasonable results, and those who survive this major procedure have an infinitely better chance of survival.

In Beer's monograph on bladder tumors, he made the statement that there is change of type of malignancy, the low grade tumors becoming highly malignant and vice versa. He noted this specific occurrence in 22 cases. In my own series of 25 cases in the last seven years, graded according to the method of Broders, all patients with grade 3 and 4 malignancy are dead with the exception of 1, a patient who had total removal of the tumor by resection. Those with grade 1 and 2 malignancy are all living. So from my experience and those of others, we can predict safely that those with low grade malignancy reasonably can be assured of a long period of usefulness and perhaps even cure if they will cooperate and follow instructions.

I congratulate Dr. Wear on his excellent paper, and suggest that he continue his investigation of bladder tumors.

THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Allergy in Clinical Practice. By Staff Members of the Cleveland Clinic, under the direction of Russell L. Haden, M. D., F. A. C. P., chief of the Medical Division. Edited by J. Warrick Thomas, M. D., F. A. C. P., chief of the Section on Allergy. Cloth. Price $5. Pp. 354, with 92 illustrations including 14 subjects in color. Philadelphia: J. B. Lippincott Company, 1941.

This volume, prepared by staff members of the Cleveland Clinic under the direction of Dr. Russell L. Haden, primarily stresses the problem of allergy as a factor in general medicine. The subject matter and its manner of presentation will appeal to the general practitioner and the medical student in particular, and the fact that it is edited by Dr. J. Warrick Thomas, chief of the Section on Allergy of the Cleveland Clinic, is assurance of its interest to specialists in the field.

Detailed discussion of the various concepts of the mechanism involved in allergic manifestations and their accompanying pathology is wisely omitted. With few exceptions each chapter deals with one of the specific diseases or conditions commonly considered allergic, prepared by a particular staff member from the various sections of the medical division of the Clinic, often with the collaboration of Dr. Thomas. The general treatment of each subject is similar including symptomatology, allergic etiology and diagnosis, treatment, specific and non-specific, interesting case histories, and a valuable summary.

To the reviewer the chapters dealing with some of the less commonly recognized allergic diseases are the most interesting. These include the contact and atopic dermatoses, drug eruptions, ocular manifestations of allergy, endocrine consideration in the allergic patient, epilepsy and cyclic vomiting. Tables on pages 118 to 121 giving the differential

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characteristics of common allergic dermatoses are especially valuable for the general practitioner.

The general set-up of the book including the numerous illustrations, the type, references and index is excellent, and the subject matter most worth while. It is recommended as a reference manual for use in general practice. W. A. M.

The Doctors Mayo. By Helen B. Clapesattle. Foreword by Guy Stanton Ford. Cloth. Price $3.75. Pp. 822, with 65 illustrations. Minneapolis: The University of Minnesota Press, 1941.

H. B. Clapsattle's biography of *The Doctors Mayo* presents a fascinating picture of almost a hundred years of American medicine in the Middle West. The book describes the life of the American frontier, the ambitions, the thirst for knowledge, and the possible career facilities of energetic men of the Nineteenth Century. William Worrall Mayo, the real doctor, left England in 1845 at the age of 25 years, and came to the New World as a pioneer in the true sense. Asiatic cholera in 1849 in Indiana brought Father William Mayo into medical activities, taught him hygienic measures, and installed in him a desire to study medicine at La Porte University where he enrolled at the Indiana Medical College. Microscopy, the use of anesthetics, and the pathological indications of the urine fascinated the young practicing physician who carried "water casting" from quackery back into an important aid to diagnosis. He described the deductions from chemical and microscopic urine analyses in the *Medical Transactions*. A tempting offer from the new Missouri Medical College, the later school of Medicine of Washington University, kept Mayo for a short period only in St. Louis, just long enough to obtain a second M. D. degree. However, recurrent attacks of cholera and malaria made him hitch up horse and buggy and state "I'm going to keep on driving until I get well or die." The lure of the Mississippi, the curiosity of a wanderer to see and to know the Great Lakes' country and its wildness culminated in Mayo's farm activities in the Cronan Precinct of the Minnesota Valley interspersed with the rural practice of medicine. A "man of hope and forward looking mind" was aided by a "woman of tolerance, understanding and equanimity" to establish in Rochester in 1863—the social capital of a rich wheat district connected by rail with the wheat market Chicago—a prominent place as physician, politician, and farmer.

Success and set-backs in his practice were shared by the two sons, William and Charles, who served a thorough apprenticeship in medicine and surgery long before they entered medical school. No wonder that William was convinced that he and his brother could be nothing else but doctors. Success and recognition of the Mayos continued with the building of a hospital in 1883. William James Mayo was graduated from the University of Michigan on June 28, 1883. Charles Mayo, to get a different viewpoint of medicine, went to the Chicago Medical College from which he was graduated on March 27, 1888. In

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BOOK REVIEWS

1883, William James Mayo, 22 years old, joined his father in practice. When Charles in 1888 joined his father and brother, he made himself look older by wearing whiskers "like an old buffalo robe." Antisepsis was practiced in Europe by 1889, and the opening of a new hospital in Rochester made its application and the newer principles of surgery feasible. The death rate in abdominal surgery was about 17 per cent. After a "study visit" in 1890 with Dr. Price (Philadelphia), Dr. Will reduced the mortality rate in gynecological operations at the Mayo Clinic to 5 per cent. Dr. Will was eager to learn more and so he worked and studied with Fenger, Senn, Ochsner, Murphy in Chicago, and with Osler and Halsted.

At the Mayos' hospital, specialization in the various fields of medicine gradually developed, and the brothers surrounded themselves with keen helpers. The local medical practice became too small to permit concentration on surgery alone. The time factor was of the utmost importance since better railroad schedules were ready for incoming patients and for spreading the achievements of the Mayo Clinic to visiting physicians.

In 1905, 4,000 operations were performed at St. Mary's hospital. As need for assistance became more imperative, the Mayos engaged with unerring judgment excellent practitioners. Practice went ahead, the hospital had to be enlarged several times, and by 1919, 60,000 patients had been treated. The fee question was regulated according to Dr. Will's expression, "If a man can pay, he will." Doctors, nurses, and four other groups were exempt from fees. The Mayos had only one pocketbook, one bank account, so their decision to give $2,000,000 to the University of Minnesota as the Mayo Foundation did not necessitate arguing.

The increased growth of the Clinic and the interest in scientific achievements required enlargement of the staff. There again Dr. Will "did the best day's work he ever did for the Clinic" in appointing Henry Plummer. A year later, he added Starr Judd to his staff.

When Dr. Will in 1899 reported on 105 operations on the gallbladder and its ducts, many a surgeon found the Mayos' experience and results utterly incredible. The personal investigation brought to light that the Mayos never claimed credit for something which was not original with them. For instance, the no-loop method was referred to as a Mayo operation, but Dr. Will disclaimed credit for it, saying "all he and Charlie had done was gather up good ideas from many men, assemble them as a whole, and tie a string around them, so that all they could claim credit for was the string." Drs. Will and Charlie were not the brilliant surgeons in the sense of outstanding technical matters, neither did they contribute something sensationally original, they were concerned that the Clinic should know, test, and practice the very best methods available regardless of who had discovered them.

Accessory sciences and divisions for various branches of medicine rounded the circle of the Mayo Clinic.

Many honors from near and far were bestowed upon the "surgical travelers of the world," upon "the dignified Dr. Will and the gentle Charlie."

When in 1928 the Clinic Building was opened, Dr. Will was 67 years old, active and alert. Nevertheless, he retired from the operating room. Soon Charlie was forced to give up operating as the result of a retinal hemorrhage. Charlie died in Chicago on May 26, 1939. Dr. Will passed away on July 28, 1939, at Rochester. "With their passing, the curtain falls on a pioneer era in American Mid West medicine."

My first visit to the Mecca of American surgery remains vividly in my memory. We had been told of the achievements, the colossal statistics, and the Rochester men as students. Featherstonhaugh's *Canoe Voyage up the Minnay Sotor* and Gerstäcker's *River Pirates of the Mississippi* had left imprints of the territory. However, the flatness of the Zumbro River region was most disappointing. The St. Peter or the Taj Mahal of the Prairie, that is, the new Clinic Building, greets one from the far distance like the pyramids in the Sahara Desert.

The book contains much regional history, much interesting medical information, and brings to a reader admiration for the Mayos and for the successful pioneer physicians. H. H. R.

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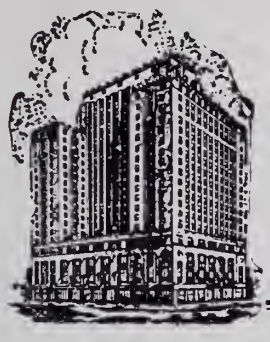

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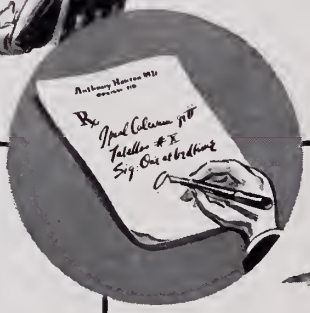

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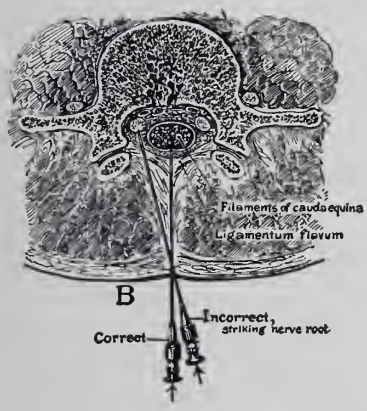

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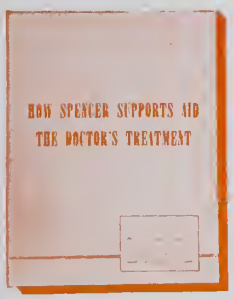

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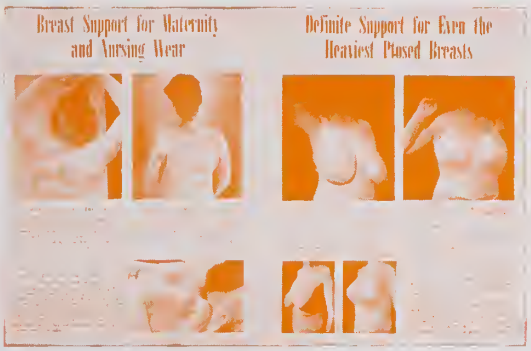

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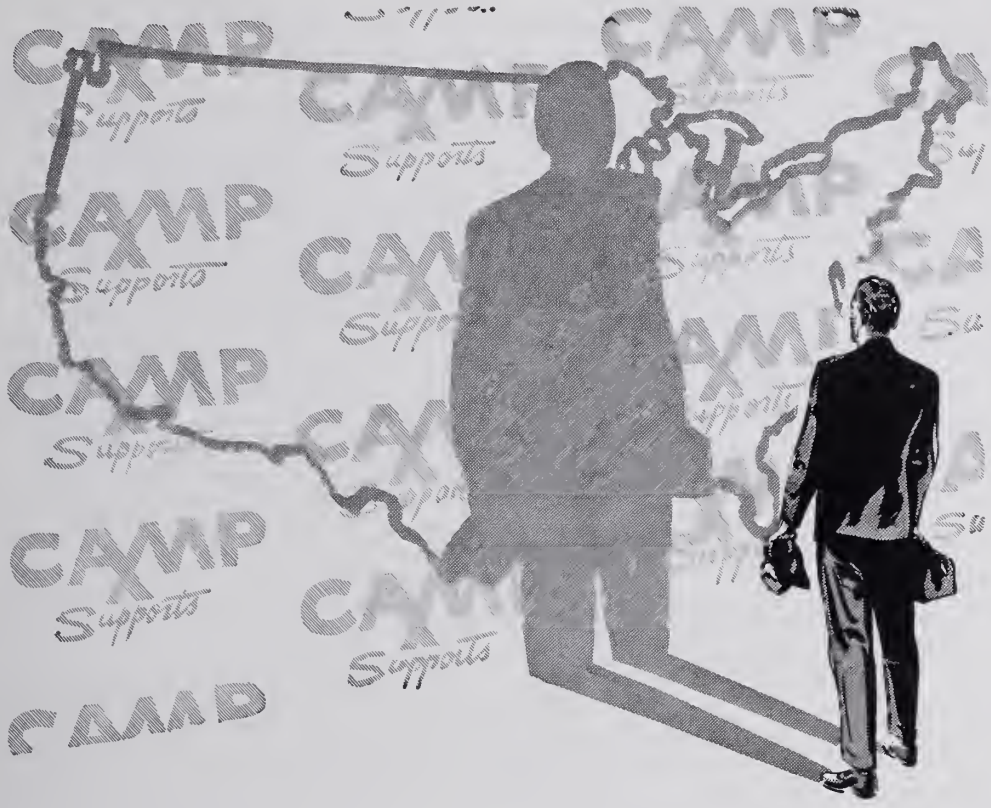

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[Entered as second class matter, June 30th, 1903, at the Post Office at Milwaukee, Wis., under Act of Congress March 3rd, 1879. Transferred to Madison, Aug. 1st, 1929.]
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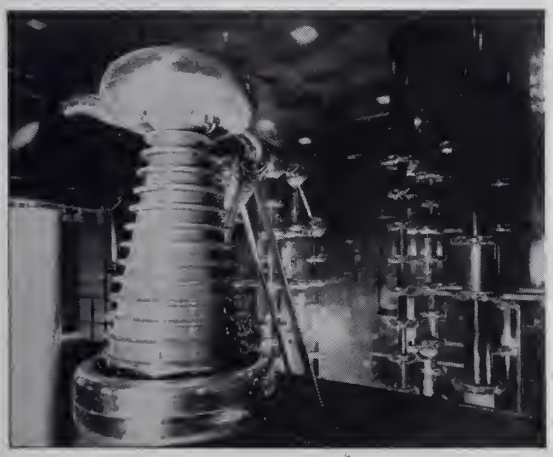

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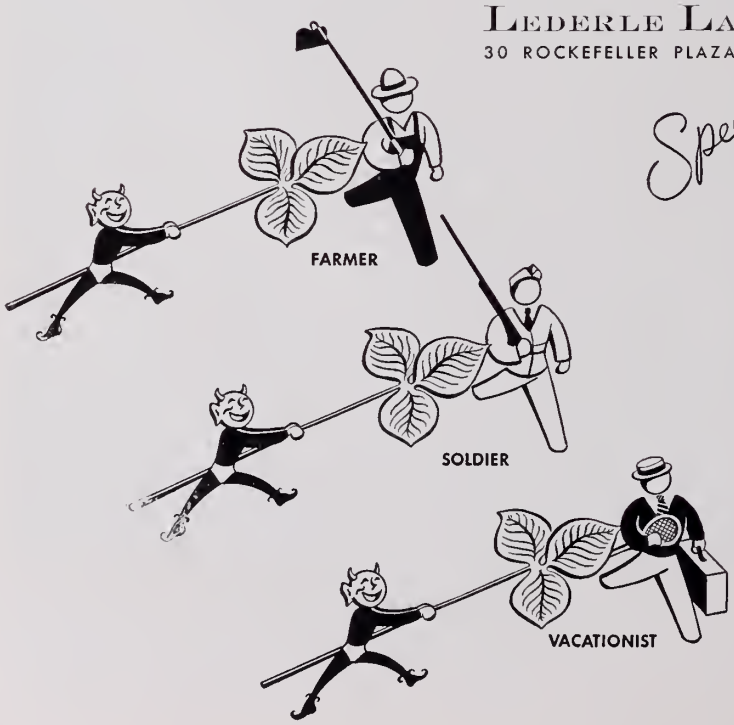

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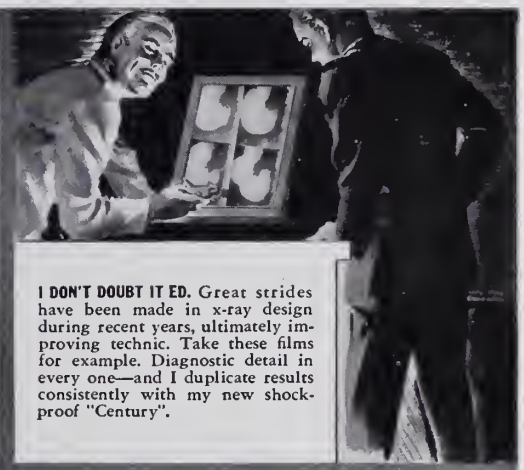

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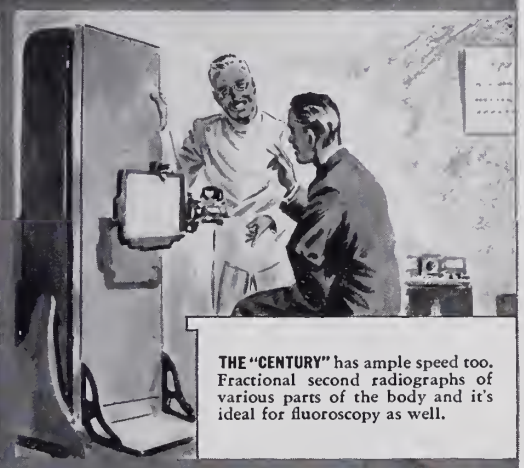

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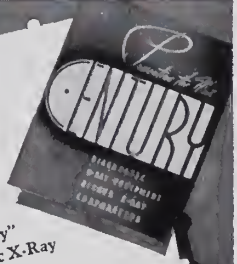

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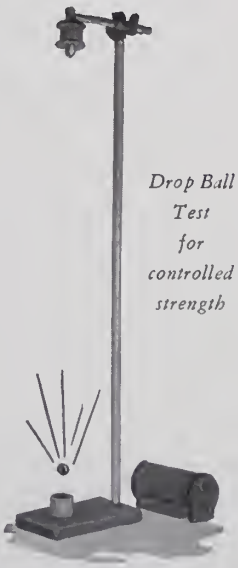

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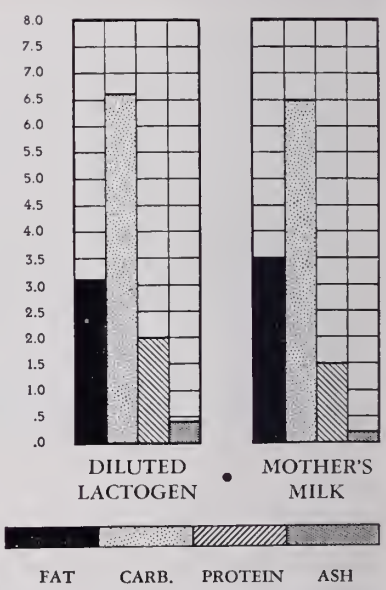

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1937. Appertizing or the Art of Canning; Its History and Development, A. W. Bitting, Trade Pressroom, San Francisco.
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THE WISCONSIN MEDICAL JOURNAL

VOLUME 41, NO. 6 Copyright, 1942, by The State Medical Society of Wisconsin JUNE, 1942

Sulfathiazole For Infections in the Urinary Tract*

By RUSSELL D. HERROLD, M. D.**

Chicago

DURING the last eighteen months sulfathiazole (furnished through the courtesy of the Department of Medical Research, Winthrop Chemical Company, Inc.) has been administered to approximately 800 patients with various types of infections in the urinary tract, about three-fourths of whom had gonococcic infection. While the administration of the sulfonamide compounds has simplified the management of urinary infections there are still many problems to be considered even with a more efficacious chemotherapeutic agent such as sulfathiazole. Frequently an active infection may be changed to a subclinical or carrier type of infection requiring intensive laboratory tests for the determination of bacteriologic cure. Also, it is important to recognize the various causes that contribute to chemotherapeutic failure.

Gonococcic Infection in the Male

A study has been made, in association with Dr. John M. Henry of Chicago, of 425 male patients with gonococcic infection who were seen during a period of one year at the clinic of the Illinois Social Hygiene League. The analysis was made three months after the end of the year. The admission rate of new patients was approximately the same each month and the average period that elapsed after chemotherapy was seven and a half months. Since facilities for cultures were not available at this time, the management of patients corresponded closely to that in private practice and attempts were made to obtain a reasonably long follow-up period.

Three hundred of these patients were given sulfathiazole in a dosage schedule of 4 Gm. daily for a period of five days. One hundred and twenty-five patients were given a total of 16 Gm. in a period of six days with a schedule of 4 Gm. the first day, 3 Gm. each on the second and third days, and 2 Gm. daily on the fourth, fifth and sixth days. No significant difference could be noted in the results of the two groups.

Often it is difficult to differentiate between a clinical relapse of infection and reinfection. Sixty-four out of the group of 425 patients returned with active, acute infections sometime during the fifteen month period of observation. We believe, however, that two-thirds of this group had latent infections for varying periods of time, but comparatively few longer than six months. Therefore, it would seem that approximately 1 out of every 10 patients to whom sulfathiazole had been administered were symptomless but infectious for a period up to six months. Unfortunately, many such latent infections cannot be made clinically active by the usual provocative tests, and, therefore, become an epidemiological hazard unless the patients can be convinced of the need for long follow-up periods. All patients should be instructed in regard to suitable measures for the prevention of infection to others during a six months' period after chemotherapy. Twenty-five per cent of the total group were seen for a period less than thirty days, and, here, 16 patients were known not to be cured by one course of sulfathiazole. A sufficient number of these early failures were cured by a second course of sulfathiazole to warrant repeated administration as a routine measure in such patients.

While there may be some question of the actual additional value of local treatment in connection with chemotherapy, we are con-

* Presented at the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

** From the Department of Urology, University of Illinois College of Medicine.

vinced that it is a definite aid in obtaining the cooperation of patients. Provocative measures also are used even though not as effective as formerly. In the determination of cure it would be ideal if facilities for cultures were generally available, but, as they are not, more intensive microscopic examination should be made. Since but few patients have any urethral discharge following one course of sulfathiazole the sediment of the first voided urine must be examined, and to obtain the best results not more than 1 ounce of the first voiding should be collected and centrifuged at high speed for at least ten minutes. In patients known to have had posterior infections it is best to massage the prostate before the patient is permitted to urinate. All exudates should be stained by the Gram method.

About four years ago Dr. Edward Palmer of Chicago and I selected a group of patients at the University of Illinois who were symptomless at the end of a three weeks' course of sulfanilamide. Frequent examinations were made and it was found that 50 per cent had positive smears even though there were no symptoms of gonorrhea. These patients became gonococcus free in periods varying from two to sixty days without further chemotherapy, apparently through the mechanism of the body forces. I believe the same condition exists but in a lower percentage of patients following one course of sulfathiazole. The period of infectivity is shorter, as a rule, than in the group of patients who eventually develop clinical activation.

It is important to recognize the various causes of failure of chemotherapy in gonorrhea, of which there are several types. Localized complications along the urinary tract must be considered, such as (1) paraurethral sinusitis, (2) parafrenal abscess or fistula, (3) acute or chronic follicular abscess, (4) cowperitis, (5) stricture, and (6) prostatitis, usually of the chronic indurated type.

Special treatment, chiefly drainage, must be given in these complications and should be done after the patient has been on sulfathiazole for twenty-four hours or longer. Another type of failure is due to the development of sulfonamide-fast gonococci. Here it may be necessary to use combined fever and sulfathiazole therapy, and chemotherapy should precede fever treatment by eighteen to twenty-four hours. Some patients are unable to take sufficient sulfathiazole due to hypersensitiveness to the drug. A few infections are refractory from the onset of chemotherapy with slight or no favorable clinical response due to some unknown factor or factors that contribute to a subnormal body resistance. In such infections chemotherapy should be discontinued after a short trial and resumed at a later date or combined with fever therapy.

Recently several patients have been seen who had atypical infections. The objective symptoms were comparatively mild even though in some instances the patients had never had gonorrhea previously. Generally these infections were somewhat similar to nonspecific urethritis. Prolonged search of the smears revealed a few extracellular gram-negative diplococci, typical of gonococci. In some instances the diagnosis was confirmed by culture. All of this group were more resistant to chemotherapy than the typical infections. It may be that such atypical infections were contracted from patients of the carrier type who had previously been given one of the sulfonamide drugs. It is well to defer the diagnosis in apparent nonspecific urethritis until several examinations have been made.

Recent gonorrhea case reports in the State of Illinois were more than 14 per cent higher than one year ago. This condition may be due in part to intensified case finding activities. At any rate, I believe it is indicative of very little reduction in the incidence of gonorrhea, even though it is a conservative estimate that 90 per cent of all infections have had the benefit of sulfathiazole or sulfapyridine during the past year. When one considers that at least 25 per cent of all patients with gonorrhea default before a suitable follow-up period, and a significant number of all with infections become carriers, then it is obvious that the problem is far from solved. Since under the present scheme of treatment patients are being more widely distributed among the profession, I

believe a more intensified campaign is in order to educate the patient as well as the public in general in regard to the limitations of the present management of gonorrhea.

Chronic Nonspecific Prostatitis

I believe that sulfathiazole or any of the other sulfonamides seldom is indicated for chronic nonspecific prostatitis except in those few instances associated with acute symptoms or with infection of the bladder and upper urinary tract. It is rare to note any substantial reduction of the pus or bacterial content of the prostatic secretions in such infections following chemotherapy. The majority of bacteria of nonspecific prostatitis are quite resistant to the sulfonamides, and, in addition, the concentration of the drug in the prostatic secretions is low as compared to that in the urine. Here is an example in the urinary tract that is comparable to conditions in general of the widespread use of the sulfonamides without sufficient indication for chemotherapy. It must be remembered that a certain, though small, percentage of all patients will develop such hypersensitiveness that later administration for more serious conditions becomes a definite drug hazard, and, consequently, such patients sometime in the future may be denied the benefit of chemotherapy for infections otherwise rating a high mortality. I do not know of any exact figures on the duration of hypersensitivity but it would seem to exist for a substantial period of time.

Bladder and Upper Urinary Tract

By far the most consistently successful results have followed chemotherapy of the acute type of infection in the bladder or upper urinary tract where the onset has been sudden and not associated with an obvious or suggested history of other complicating factors. In most instances of such success the specific etiological factor has been one of the various gram-negative groups of bacteria. Typical of a good response is the syndrome in women with a sudden onset of frequency and burning on urination, often associated with tenesmus and terminal hematuria. The symptoms are similar to acute gonorrhea in women from which condition differential diagnosis must be made.

I prefer a full dosage of 4 Gm. daily of sulfathiazole for five days as a routine procedure at the end of which time further chemotherapy is dependent upon a careful examination of the stained sediment of a catheterized specimen of urine. Should bacteria be found chemotherapy is continued, usually with a reduction of dosage, but not longer than a total of ten days. If and when the smears and clinical symptoms indicate apparent cure, cultures in addition to smears should be made after a lapse of at least one week from the discontinuance of chemotherapy to assure actual bacteriologic cure. In the male, similar acute and uncomplicated infections are less common, but, when present, a high rate of cure can be attained. However, cultures of the prostatic secretion should be included during tests of cure.

With regard to species susceptibility to sulfathiazole, we have noted very little difference in the common infections of the bladder and upper urinary tract, with the exception of Pseudomonas and Streptococcus faecalis which are definitely the most resistant. Actually, in uncomplicated infections we have found Proteus as susceptible as the colon bacillus group, but because the Proteus bacillus is so frequently associated with other pathologic lesions that contribute to failure there is a falsely apparent increased resistance of Proteus bacilli.

Failure of cure of infections of the bladder and upper urinary tract with a course of five to ten days of sulfathiazole is strongly suggestive that there is some associated local pathologic condition in the urinary tract that must be corrected before there is hope of success with chemotherapy. In the presence of symptoms suggesting complicating pathologic conditions, chemotherapy should not be attempted until a complete urinary examination is made. There is danger that chemotherapy in some instances may mask the symptoms of surgical conditions that ought to be corrected promptly.

The various associated pathologic conditions that must be considered are familiar to all of you, but I have been impressed with a rather high incidence of "silent calculi" somewhere along the urinary tract as a cause of failure, including the often overlooked calculi in the prostate. Of course, urinary stasis anywhere in the urinary tract is a contributing factor to failure even though there may be symptomatic improvement for a brief period of time. Reduction of the pus cell content of the urine may occur, but never actual bacteriologic cure. With regard to the various types of cord bladder, I prefer some other method than the sulfonamides to protect the upper urinary tract. Here small doses of methenamine and acidification have a place, and may be continued safely for an indefinite period of time.

Small Dosage of Sulfathiazole

A number of patients have been given sulfathiazole in small dosage, such as 10 grains daily, for prolonged periods of time. One group consisted of patients, chiefly male, who were not cured by one standard course and in whom no evidence of associated pathologic conditions requiring surgery could be found. Invariably these patients gave a history of infection for many years. The kidney function was not substantially below normal. None was cured, but a reduction in pus cell content of the urine often followed. Eventually there was a relapse to the former state on discontinuance of the drug. It is questionable whether chemotherapy in such infections is worth while except perhaps intermittently when symptoms become acute. Another group with marked reduction of kidney function, such as occurs in the late stage of polycystic disease of the kidneys, was given a similar schedule over a long period of time. Here, I believe, such administration is justified since no urinary antiseptic other than the sulfonamides can be excreted sufficiently to be of any value. Also, such medication may be worth while in chronic bilateral and nonsurgical infections of the upper urinary tract since the prognosis is hopeless under ordinary management.

The Prophylactic Use of Sulfathiazole

As regards chemotherapy to prevent so-called instrumental chills and fever, the chief point to stress is the necessity of administration for a period of twenty-four hours before the passage of cystoscopes, sounds, or catheters, particularly in patients known to be susceptible to reactions following manipulation. It is well to continue sulfathiazole for a few hours after instrumentation. I do not know the minimum amount that would serve as a prophylaxis since I now give routinely about 2 Gm. during the twenty-four hour period preceding examination. Previously I had found that a similar dosage for twenty-four hours following instrumentation did not always prevent chills and fever. Short and intermittent courses of the sulfonamides seldom produce hypersensitivity. Administration of the drug longer than five days is usually necessary to produce such a state, and is associated frequently with the reaction of drug fever and often with some type of skin eruption.

Toxicity of Sulfathiazole

Because there is comparatively low incidence of immediate and discomforting toxic effects, there may be a tendency to slacken the observations that frequently are predictable of approaching serious reactions. Three of our series of clinic patients developed jaundice and had they not been seen daily, and sulfathiazole discontinued promptly, a severe hepatitis might have followed. A few others had symptoms referable to the urinary tract suggestive of excessive acetylated crystals and medication was discontinued, which may have avoided definite sulfathiazole calculi. While in general it is not necessary to see patients daily in private practice, it is advisable that they be seen every second or third day and carefully instructed at the onset of chemotherapy as to the type of reaction that requires discontinuance of the drug. A general appraisal of the patient should be made in regard to toxic effects, urine examined, temperature taken, and blood examinations made when the symptoms so indicate.

Other Sulfonamides

Sulfapyridine is about equally as effective as sulfathiazole in the treatment of gonococcic infections, but because of a high incidence of toxic effects sulfathiazole is preferable. The sulfanilamide derivative known as sulfacetamide is slightly less toxic and slightly more effective than sulfanilamide, but is inferior to sulfathiazole for gonorrhea and other infections of the urinary tract. I have had a very limited experience with the latest available sulfonamide, sulfadiazine, but it may replace sulfathiazole because of the reported lessened toxicity. It apparently retains sufficient toxicity so that it can be said the ideal chemotherapeutic agent has not as yet been found. It is apparent that all the general principles governing the use of sulfathiazole and also the limitations will apply equally to sulfadiazine. A recent report of toxic psychosis in 3 per cent of patients treated with sulfadiazine may indicate caution is necessary in the use of this drug in ambulatory patients. Animal experiments indicate there is some danger of kidney damage although apparently less so than with sulfapyridine or sulfathiazole.

Walter M. Kearns, M. D., Milwaukee: Dr. Herrold's reaction to sulfapyridine interests me especially. It parallels my own reactions to this drug. At the meetings of the American Medical Association in St. Louis in 1939 and of the American Urological Association in White Sulphur Springs shortly thereafter, we learned about the markedly insoluble salt, sulfapyridine acetylate, which packed the renal tubules of experimental dogs. Also, Dr. Robert A. Moore reported the presence of renal concretions of the same insoluble salt in the human kidney at autopsy. This information coupled with our previous clinical experience of the marked greater toxicity of sulfapyridine, especially in gastro-intestinal upsets, as compared with the other sulfonamides, led us to discontinue its use in our practice. Its greater toxicity, the immediate damage to the kidney, and the remote possibility of initiation of stone formation are all serious objections.

The drugs of the sulfonamide group have been rated by the commercial laboratories as to their specificity of action on certain organisms. Various charts with various numbers of plus signs indicate the degree of specificity of bacteriostatic effect on various strains of organisms. These test tube effects are being translated into clinical effects by practitioners who, without bacteriologic investigation, are attempting to use the culture results as a guide, losing sight of the fact that these bacteriostatic effects are only relative. Witness today's widespread and gratifying use of this family of drugs in the eradication of infections of the bacillary group, whereas in the early days following the introduction of sulfonamide, it was believed to exert a quite specific effect on coccal groups.

So this exact specificity is not always observed in clinical application. True enough, several reports, notably those of Dr. Herrold and of Dr. E. N. Cook, indicate certain preferences as demonstrated in culture and in clinical effects. Moreover, while in some of the large centers urinary cultures are carried out routinely, by far the great bulk of urinary infections throughout the country are treated without benefit of such study. Consequently, the reaction of the individual patient becomes a much more important guide. The drug naturally sought is one with a high degree of safety and a wide range of bactericidal effect.

Following the use, in turn, of sulfanilamide, sulfapyridine, neoprontosil, the discarded sulfamethylthiazole, and sulfathiazole, we took up the use of the preparation sulamyd, which was supplied by Dr. Max Gilbert of the research department of the Schering Corporation. Not only has it a wide range of bacteriostatic action on the various organisms, but it also possesses a definitely lower toxicity than any of the previously tested preparations.

The reports of Drs. N. G. Alcock, N. S. Ackerblad, H. W. Walther, L. P. Dolan, R. S. Irwin, and H. W. Bruskewitz, and the very recent contribution of Dr. H. H. Young and his associates reveal experiences which parallel quite closely our results.

During the last two years we have administered this new preparation to over 250 patients in hospital and office practice, and we believe it approaches closely the ideal drug. It was used in patients with pyelonephritis, cystitis, and gonorrhea, and following operations for urinary stone, prostatic resection, and prostatectomy. Various types of infections in the bacillary and coccal groups were treated successfully. There was no recurrence of stone formation, crystalline deposit, or hematuria.

In summing up, our experiences with sulamyd shows it to be definitely the least toxic and the most potent preparation with widespread efficacy in various types of infection.

OUR RESPONSIBILITY

It is the responsibility of the attending physician to impress upon the mother the importance of vaccination against smallpox. Wisconsin's children need not die from smallpox if physicians will vaccinate each child during the first year of its life.

Chemotherapy With the Sulfonamide Compounds*

By HENRY F. HELMHOLZ, M. D.**
Rochester, Minnesota

THE discovery by Domagh[1] in 1935 of the chemotherapeutic effect of sulfanilamide on diseases caused by hemolytic streptococci, has opened a new era in the treatment of disease. Just at a time when specific immune serum was tending to become the treatment of infectious diseases, particularly of pneumonia, a new group of drugs appeared that has changed the entire aspect of medical treatment. Diseases that were considered self limited and fatal in a high percentage of cases were removed from this group and given a hopeful outlook. One of these, pneumonia, which formerly had an average death rate of 35 to 40 per cent now has a death rate of only 7 to 10 per cent. Streptococcic and pneumococcic meningitis, which previously were almost certain to have a fatal outcome with perhaps one or two recoveries in a hundred, are by sulfonamide therapy given a much more favorable prognosis; the mortality rate from these diseases has been reduced from 98 to 30 per cent, and possibly a further reduction can be effected with earlier diagnosis.

The four sulfonamide compounds that stand out most prominently are sulfanilamide, the pioneer; sulfapyridine, the drug which has improved action in the treatment of pneumonia and meningitis; sulfathiazole, with its less toxic and more widespread action, and finally sulfadiazine, which from recent work appears to be better tolerated by the body, is less toxic and seems to act equally well in pneumococcic infections of the various types. It also seems especially useful in staphylococcic infections.

Specific Indications

The specific indication for one or the other of these drugs is still a matter concerning which a great deal of work is necessary.

The question is not settled by knowing which of the drugs acts in lowest concentration on a particular bacterium in vitro or in vivo, for the location of the infection may be such that it is impossible for that particular drug to reach the region involved in a bactericidal concentration. It may be possible, however, for one of the other drugs, even though not so specific in its action, to act effectively on the infection at that site. The rapidity and concentration in which sulfapyridine enters the spinal fluid make it the drug of choice in the treatment of meningitis.

It is, therefore, necessary to know the behavior of the various drugs, the rate of absorption from the gastro-intestinal tract and the variability in this process, the rapidity with which each drug is secreted by the kidney, which if too fast interferes with the building up of high concentrations in the blood, the facility with which each enters the body fluids, the rate of inactivation by acetylization, the toxic influence of each on the erythrocytes and leukocytes, and the effect on the skin, the central and peripheral nervous system, the liver, the kidney and the gastro-intestinal tract. If the kidneys are damaged, or there is vomiting, the drugs normally rapidly excreted by the kidney, may pile up in the blood and produce symptoms of intoxication or crystallize out in the renal tubules, pelvis, ureters, and bladder in the less soluble acetylated form.

It is necessary to know the relative value of the various compounds in various infections, and to have sufficient knowledge of their pharmacologic action, so that bactericidal concentrations can be built up rapidly in the region of infection. Careful clinical observations are necessary, so that toxic reactions may be noted before they become serious.

All of the sulfonamide drugs can be given by mouth. Unfortunately vomiting, in addition to the vomiting often caused by the dis-

* Presented at the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

** From the Section on Pediatrics, The Mayo Clinic.

ease itself, frequently is induced by them. Fortunately, these drugs also can be given parenterally; sulfanilamide in 0.8 per cent solution can be given intramuscularly or subcutaneously, and the sodium salt of sulfapyridine, sulfathiazole and sulfadiazine can be given in 5 per cent solution in freshly distilled water by the intravenous route only.

Which one of these four drugs is to be used in any particular infection that comes up in the practice of any physician? Sulfanilamide is still the drug of choice in any infection with hemolytic streptococci in whatever form it appears, and numerous infections such as chancroid, lymphogranuloma, meningococcic infections, trachoma and actinomycosis. Sulfapyridine is used in all the pneumococcic as well as gonococcic infections, and because of its ease of concentration in the spinal fluid, in all infections of the meninges. Sulfathiazole is used in gonococcic, pneumococcic and staphylococcic infections, and it seems to be the choice of the four in pyogenic infections of the urinary passages. Sulfadiazine is likely to become the drug of choice in many infections in which the other drugs have been used, because of its lack of toxic effects, the ease with which the high levels can be attained in the blood, and a greater solubility of the acetylated form, which makes precipitation in the urinary passages less likely than with sulfapyridine and sulfathiazole. Its value in pneumococcic and staphylococcic infections has been proved.

Sulfanilylguanidine differs from the other four sulfonamide compounds in that it is only with great difficulty absorbed from the intestinal tract, and its use in bacillary dysentery is based on its bactericidal action within the lumen of the intestine.

Long[2] in a recent publication gives a complete table in which he lists the various bacterial infections successfully treated with sulfonamide compounds.

Promin

Another sulfonamide compound, disodium p, p′-diaminodiphenylsulfone-N, N′-didextrose sulfonate (promin), is outstanding because it is capable of exerting a deterrent as well as a curative effect on experimental tuberculosis in guinea pigs. Feldman, Hinshaw and Moses[3] have found that in those animals which received promin regardless of whether the administration of the drug was started before, at the same time as or from four to six weeks after inoculation with tubercle bacilli, the expected course of the disease was altered unmistakably. The deterrent effect of the drug on the infection was indicated by the longer survival time of the treated animals. In one experiment, although all of the control animals were dead at the end of six months, 84 per cent of the treated animals were living, and the 16 per cent that died did not die of tuberculosis. While the infective agent was capable of producing in the untreated controls a progressive malignant infection, the histopathologic characteristics of the disease in the animals that were treated with promin were those of a process that was healing rather than one that was progressing. In one group of sixty-eight guinea pigs that were treated with promin, at variable periods up to six weeks after infection, recognizable lesions of tuberculosis could not be found in twenty-nine or 42.6 per cent, at a time when the control group had died of tuberculosis.

This definite chemotherapeutic success in the treatment of tuberculosis in the guinea pigs seems to provide hope that eventually a chemical agent will be found that will be of therapeutic value for tuberculosis of human beings.

It would be impossible in this short paper to attempt to outline the specific indication for these drugs, their dosage, mode of administration and various toxic effects that these compounds have; so with this general introduction of the subject I will use the rest of my time to discuss with you the use of these compounds in the treatment of the pyogenic infections in the urinary passages, a subject in which I have been actively interested for many years.

Treatment of Pyogenic Infections of the Urinary Tract

Before the introduction of sulfanilamide as a urinary antiseptic the chemotherapy of urinary infections rested on the action of

formaldehyde split off from methenamine, the action of beta-oxybutyric acid resulting from the ketogenic diet, and on mandelic acid, excreted as such. A definite degree of acidity, pH 5.5 or less, was necessary in order to obtain bactericidal action in the urine. This degree of acidity may be impossible to attain if the kidneys are damaged. With the use of sulfanilamide and sulfathiazole the reaction of the urine plays practically no role in successful treatment of most urinary infections. In more recent studies high concentrations of the drug in the urine, that at first were thought necessary, have been shown to be unnecessary and correspondingly low dosages have given just as good results. Dosages of 5 to 6 Gm. a day of sulfanilamide were given when more recently dosages of 2 to 3 Gm. a day were seen to be sufficient to clear up infections with the gram-negative bacilli, such as Escherichia coli, Aerobacter aerogenes, and others. The advantage of the sulfonamide compounds over drugs requiring an acid urine is twofold: It was not necessary to take account of the reaction of the urine, and the drug is excreted in bactericidal concentrations by a kidney so badly damaged that the necessary acidity for bactericidal action with methenamine and mandelic acid could not be reached. As sulfanilamide continued to be used, one handicap became evident. Infection with strains of Streptococcus faecalis which in the urologic literature before the introduction of sulfanilamide played a relatively minor role, now figured very prominently in the treatment, and many physicians who have never encountered a patient with a streptococcic infection, suddenly found themselves with more than a few on their hands. Infections with this organism did not clear up with administration of sulfanilamide; in fact, they seemed to appear under this therapy. Treatment with sulfanilamide over night may rid a patient of his gram-negative bacilli and leave behind an infection with a pure culture of Streptococcus faecalis.

The Streptococcus faecalis is the fly in the ointment of sulfonamide therapy. I recently have finished a study of the comparison of

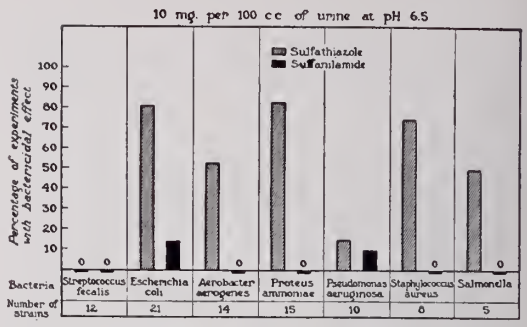

Fig. 1. Bactericidal effect of sulfathiazole and sulfanilamide in low concentrations in the urine.

the effect of sulfanilamide and sulfathiazole* on six of the common bacteria found in urinary infections. There can be no doubt of the superiority of sulfathiazole over sulfanilamide in the treatment of urinary infections with these bacteria (fig. 1). It is evident, however, that neither of these drugs is useful in the concentrations tested for streptococcic infections in a nearly neutral urine, pH 6.5. My former studies indicated that sulfathiazole was much more efficient in an acid urine, pH 5.5, than in a more alkaline one at the same concentrations of the drug. It, therefore, became of interest to see what this streptococcus would do in various degrees of acidity and concentration of the drug. Such a high degree of variability had been found in the forty-one different colon bacilli, that a large number of strains of Streptococcus faecalis were used for this study. Just as with the colon bacilli, strains were found that were very much more resistant than others. Since urine with a pH of 5.0 was used in these studies, the question arose as to how close was the death point of the Streptococcus faecalis from acidity alone. Therefore a series of experiments was performed with normal urine with a pH of 5.0, 4.9 and 4.8, and it was found that although at pH 5.0 there was growth of Streptococcus faecalis in practically all of the experiments, at pH 4.9 there was growth in roughly only half of the experiments, and at pH 4.8 growth was the exception.

At pH 5 only 10 mg. of sulfathiazole per 100 cc. of urine are necessary to produce an

* I am indebted to the Squibb Institute for supplying me with sulfathiazole for these experiments.

almost complete lack of growth of Streptococcus faecalis (fig. 2). At pH 5.5 the concentration of sulfathiazole must be raised to 30 mg. per 100 cc. to prevent growth. At pH of 6.0 there is little inhibition of growth of the Streptococcus faecalis at 30 mg. of sulfathiazole per 100 cc. of urine, some at 50 mg. and almost complete inhibition at 100 mg.

Because it has a tendency to precipitate out in the ureters and because it does not have a greater bactericidal effect on the Streptococcus faecalis than sulfanilamide has, sulfapyridine was not used with the other common bacteria of urinary infections in this study. There is some recent work to show that it may be useful in infections with the Proteus ammoniae.

Experiments with sulfadiazine* in concentrations up to 300 mg. per 100 cc. of urine did not inhibit the Streptococcus faecalis at pH 6.5. Therefore this drug too is less useful than sulfathiazole in the treatment of urinary infections with Streptococcus faecalis.

Dosage.—An average dose of sulfathiazole for a urinary infection is from 2 to 4 Gm. per day. A concentration of 50 mg. per 100 cc. of urine can be relied on for each gram of sulfathiazole administered per day, when the function of the kidney is normal. A dose of 2 to 4 Gm. per day, 0.5 to 1 Gm. given four times a day, after meals and at bedtime, should be sufficient to clear up most urinary infections. As there are strains that are 100 to 200 times as resistant to this drug as others, it may become necessary in exceptional cases to increase this dosage. If after treatment of a patient infected with colon bacilli a gram-positive coccus that grows on plain agar is left in the urine, the patient has doubtless been freed of his bacillary infection, but he still has residual infection with the Streptococcus faecalis, and it may be necessary to acidify the urine to a pH of 6 or 5.5 to get rid of the streptococcus. If this does not prove successful, the use of mandelic acid in a dosage of 3 Gm. four times a day, after meals and at bedtime, will give results, if the function of the kidney is nearly normal.

I want especially to call attention to the prevention of infection of the bladder following postoperative catheterization. A concentration of sulfathiazole as low as 2 mg. per 100 cc. of urine inhibited most of the

* The Lederle Laboratories kindly supplied this material.

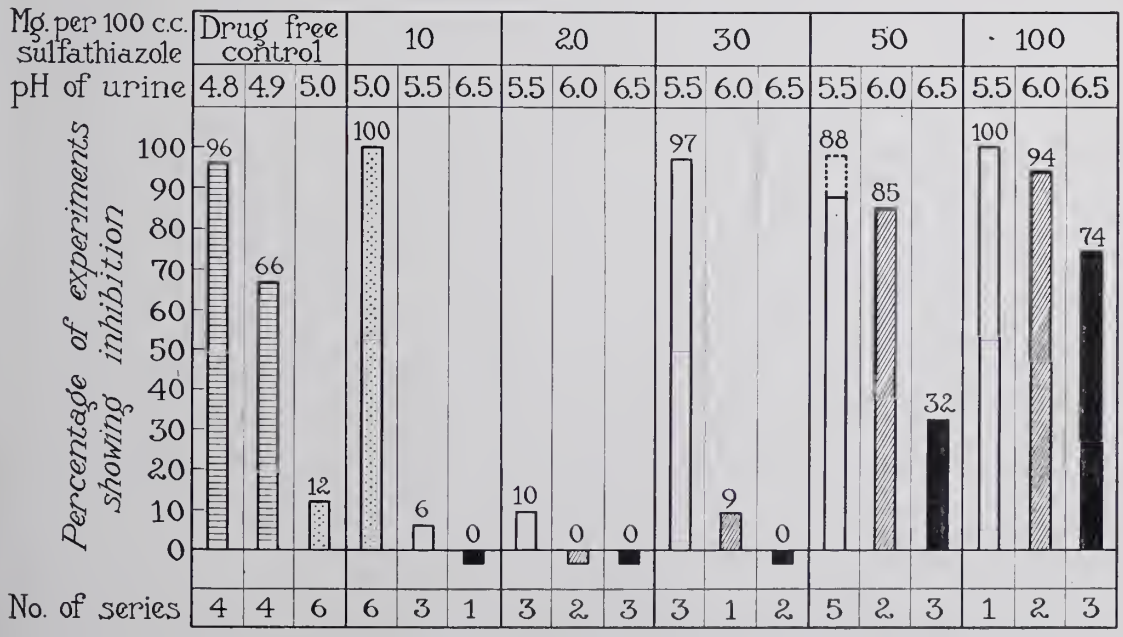

Fig. 2. Inhibition of growth of the Streptococcus faecalis with sulfathiazole.

strains of Escherichia coli and with a concentration of 30 mg. per 100 cc. practically all the strains of gram-negative bacilli and cocci were killed off, except the Streptococcus faecalis, and some strains of Pseudomonas aeruginosa. Half a grain (0.032 Gm.) of sulfathiazole, that is, 1/10 grain (0.006 Gm.) five times a day, will give a concentration of 2 mg. per 100 cc. in the urine, and 2 grains (0.13 Gm.) five times a day will give a concentration between 30 and 40 mg. per 100 cc. This dose of 2 grains (0.13 Gm.) five times a day is sufficient to prevent the oft-occurring bladder infections with gram-negative bacilli, and well deserves a regular place in the treatment of patients to be catheterized following operation. Only an occasional infection with Streptococcus faecalis has occurred, when sulfathiazole has been given after operation to prevent infection of the bladder when catheterization is necessary.

Summary

It is evident that the problem of the ideal urinary antiseptic is still an open one. It must act in low concentrations and at a reaction of the urine which can be easily reached by the damaged kidney. Sulfathiazole is the nearest approach to the ideal that we have at the present. Its only defect is the necessity of a certain degree of acidity for action on the Streptococcus faecalis.

Great progress in the treatment of disease caused by infectious agents has been made since the introduction of the first sulfonamide compound. It is to be hoped that by the cooperation of the chemist and the physician compounds will be found that act specifically on all the infections that affect the human body.

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MEETING DAYS CHANGED

The attention of members of the State Medical Society of Wisconsin is called to the fact that the One Hundred First Anniversary Meeting of the State Medical Society will be held on Monday, Tuesday and Wednesday, September 14, 15 and 16, at the Milwaukee Auditorium in Milwaukee.

For the last several years the meeting has been held on Wednesday, Thursday and Friday, but in order to conserve the time of members who attend the meeting, the days have been changed. The initial meeting of the House of Delegates will take place on Sunday, September 13.

Nontraumatic Rupture of a Previously Normal Spleen and Its Medicolegal Aspect

Clinical and Pathological Report Revealing the Embolic Manifestations of an Apparently Insignificant Traumatic Injury

By LAWRENCE L. GROSSMANN, M. D.*
Milwaukee

THE nontraumatic rupture of a previously normal spleen has always been of interest to the surgeon as well as to the clinician. A prompt and accurate diagnosis of this condition is essential to the successful management of the case, since immediate surgical interference and removal of the ruptured bleeding viscus is a life-saving procedure. The surgical management is that of splenectomy and control of secondary hemorrhage and usually presents no serious difficulties. The diagnosis of the case, however, is often very difficult, particularly since no previous disease of the spleen is known, no direct trauma has occurred, and diagnostic criteria are varied, sparse, and confusing.

"No Reliable Criteria . . ."

No reliable criteria for the diagnosis of the ruptured nontraumatic spleen have been established, other than the signs of massive intra-abdominal bleeding. Many clinical diagnostic criteria have been proposed, but none has found universal acceptance or has a high degree of accuracy. In most cases, the findings appear to localize in the right lower quadrant, and the similarity to appendicitis is and has been confusing. Kehr's and Ballance's sign, as well as sudden left thoracic pain, have been considered valuable indices of the condition by some, and found lacking by others. The chief barrier to the establishment of accurate diagnostic criteria is the rarity of the condition.

The occurrence of a nontraumatic rupture of a previously normal spleen has been known for centuries. Vanselow wrote a monograph on the subject as early as 1696 (Vanselow, M. Historiam Ruptura Lienis, Erfordiae, 1696), and there have been sporadic reports of the condition in the literature since. Perhaps a total of two or three dozen cases have been cited in the literature to the present time. Because of the rarity of the condition, no single author has had the experience of more than one or two cases in his personal series, and considerable confusion has arisen in the classification and understanding of the condition.

There are almost as many classifications and explanations as there are authors, and a detailed review of the literature on the subject to date is of no particular aid to a clearer understanding and will not be repeated here. It is interesting to note that surgical interference in this type of abdomen will reveal a postoperative diagnosis of ruptured spleen in more cases than will permit its preoperative diagnosis. Delay and procrastination usually mean the difference between life and death.

"This Grouping Is Unscientific . . ."

The more recent authors have chosen, by and large, to divide the nontraumatic rupture of the spleen into the so-called "spontaneous rupture of the normal spleen" and the "spontaneous rupture of the pathologic spleen." The latter group is presented to include spleens affected by leukemia, malaria, typhoid, etc., while the former group is intended to include the rupture of a spleen occurring spontaneously in an organ not known to be previously chronically diseased.

It seems to me that this grouping is unscientific and leads to an erroneous concept of the disease process. The difference in the two classes lies not in the fact that in one

* From the Division of Traumatic Surgery of Mount Sinai Hospital, Milwaukee.

group the spleen is pathologically involved, and in the other is perfectly normal at the time of rupture. The difference is that in the first group the disease leading to the rupture of the spleen has been present for a long time, and in the latter, the so-called "normal spleen rupture," the pathologic process leading to the rupture of the spleen is one of recent origin, in most instances occurring just before the time of rupture. Thus the term "spontaneous rupture of the normal spleen" is not scientifically correct, for a normal viscus, which has not undergone trauma and which is truly normal, will obviously not rupture.

The common habit of clinical pathologists to regard only anatomic cellular changes as significant of existing disease has enhanced this erroneous analysis. The possibilities of alteration of physiology, or physiologic disease, without anatomic cellular changes has received little attention. Thus, a pathologist who examines a section of a recently nontraumatized ruptured spleen and sees no cellular anatomic changes comes to the popular conclusion that no disease is present, and that the spleen is normal. Is it not probable that recently developed abnormal changes in the physiology of the spleen could have produced alterations sufficient to cause spontaneous rupture, and yet were not present for a sufficient time to produce cellular changes? In other words, an acute physiologic disease can be present without demonstrable anatomic cellular changes characteristic of more chronic forms.

"A Better Classification . . ."

Therefore, a better classification would be as follows:

1. Traumatic rupture of the spleen
2. Nontraumatic rupture of the spleen, in:
   a. Chronically pathologic spleen
   b. Acutely pathologic spleen

A clearer understanding of the subject would be arrived at if the terminology of rupture of a "normal" spleen would be discarded in preference to the terminology of "acutely pathologic spleen." The mere fact that the spleen did not rupture spontaneously precludes the possibility that it was normal.

The probable etiologic factors are frequently quite remote from the local area of the spleen in the nontraumatic group, and may vary from an acute circulatory disturbance with increased tension in the spleen as a result of disease elsewhere in the body, whether chronic or acute, to infections of the most trivial and remote nature. These etiologic factors may become apparent by direct association with the incident of rupture either through anatomic relationships, physiologic relationships, or mere time and sequence of events relationship. These associations are usually sufficiently well founded to preclude the possibility of coincidence. That small, distant, and apparently trivial infections can occur as the cause of rupture of a nontraumatic, nonchronic pathologic spleen is seen from the case report that follows. The role of such serious disease secondary to small, apparently inconsequential lesions occurring in industrial practice, and rupture of the spleen as the result of such remote and trivial injury or infection in industrial surgery is going to be a problem. Better understanding of the process and more careful clinical diagnostic studies may bring more cases to light in the future.

We are presenting what we believe to be the first case of nontraumatic rupture of an acutely pathologic and previously normal spleen as the result of a trivial industrial injury, of a remote nature, and its acceptance as a compensible condition in industry.

Report of Case

On May 31, 1939, the patient suffered a minor skin laceration of the left knee by the nail of a crate, while in the line of his employment. When he consulted me I treated the small wound locally, and healing progressed satisfactorily. On June 16, 1939, he sustained a minor contusion to the same knee, also in line of his employment, which resulted in the tearing off of the scab left by the previous injury. Pain in the knee developed, followed by moderate swelling, and when finally the patient presented himself it was necessary to relieve him from employment.

He was admitted to the Mount Sinai Hospital, Milwaukee, on June 17, 1939. The history given on admission was not pertinent. The present symptoms

were only those referable to the local knee injury, and general physical examination was negative except for the site of injury. The local findings were a small draining wound involving the anterior aspect of the left knee with considerable local inflammation and edema. No adenitis or lymphangitis was noted.

The laboratory studies showed hemoglobin 104.4 per cent, erythrocytes 4,970,000, leukocytes 16,450, polymorphonuclear cells 84 per cent, lymphocytes 12 per cent, and monocytes 4 per cent. The Kline test was negative. The temperature was 98.6 F., and the pulse rate 80. The urine was negative. Cultures from the lesion of the knee revealed gram-positive cocci in clusters.

Local conservative therapy was administered and progress was satisfactory, although very stubborn. A purulent synovitis was suspected, and 80 grains of sulfanilamide were administered over a period of forty-eight hours. It was then terminated because of cyanosis of the lips. No regional lymphadenitis was noted at any time.

On June 27, the patient appeared to be in excellent condition and the wound of the knee appeared satisfactory with minimal discomfort and swelling. However, at 8 p. m. he experienced a severe chill, followed by a temperature rise to 103.4 F. orally. This subsided to the subfebrile level within twenty-four hours.

On the morning of June 29, at 4:30 a. m., the patient developed diffuse generalized abdominal cramps without nausea or emesis. Shortly thereafter he had a large semiliquid stool, and a picture of shock developed suddenly. The abdominal pain localized in the right and left upper quadrants, and some discomfort was also noted over McBurney's area at a point directly beneath an old appendectomy scar. No distention was noted; no spasm or rigidity was demonstrable; no borborygmus was heard. Pain became colicky in type and moderately severe, whereas only moderate discomfort was noted to pressure in both upper quadrants. A tympanitic note became evident over the left upper quadrant, where tenderness was most marked. The temperature was 100 F. rectally; the blood pressure was 94 systolic and 78 diastolic; the pulse rate was 104 and weak in character.

The erythrocytes rose from 11,750 with 79 per cent polymorphonuclear cells to 18,500 with 88 per cent polymorphonuclear cells. A bedside roentgeno-

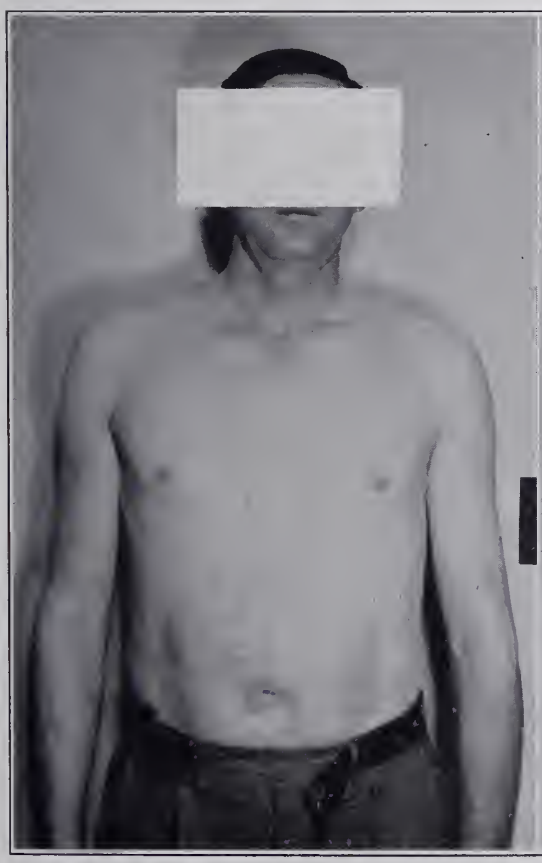


Fig. 1. Anterior view of patient's scar following surgery as of October, 1940.

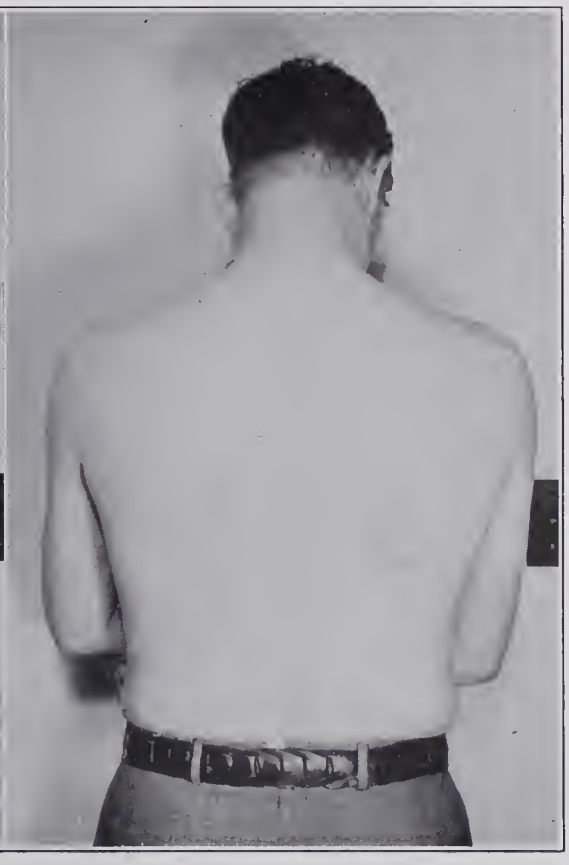


Fig. 2. Posterior view of patient's scar following surgery as of October, 1940.

gram of the chest was negative. A bedside roentgenogram of the abdomen revealed ". . . a large mass filling the left upper quadrant. Its lower border extends below the costal margin about one inch. The location and contour are very suggestive of a large spleen. . . ." It was otherwise normal. An electrocardiogram was within normal limits.

The patient remained in moderate shock despite supportive therapy and within seven hours from the onset of shock symptoms a small diffuse area of ecchymosis was evident about the region of the umbilicus. Ruptured viscus, splenic disease of an acute nature, mesenteric thrombosis, acute pancreatitis, and mesenteric thrombosis were considered in differential diagnosis.

Because of the evidence of intra-abdominal bleeding as evidenced by Cullen's sign, an exploratory laparotomy was performed on June 29. Under nitrous oxide and ether anesthetic a mid-line incision was made from xiphoid to umbilicus. The abdominal cavity was full of blood. It was readily apparent that the bleeding was coming from a ruptured spleen. The spleen was removed, the blood permitted to remain in the abdominal cavity, and a portion of the blood which had been removed was citrated and returned to the abdominal cavity. The wound was closed by through and through silkworm sutures involving all layers from skin through peritoneum. Intravenous infusion was administered during the course of surgery, and the patient was returned to his room in good condition.

The postoperative course became stormy almost at once. Peculiarly, the healed lesion of the knee again became suppurative and drained frank yellow pus. Five days postoperatively the patient developed a type XVIII pneumococcic pneumonia, and serum was administered to a total of 180,000 rabbit units. Three consecutive blood cultures were sterile. The clinical course improved, the symptoms subsided, and the temperature became normal. After a brief afebrile course, the fever returned and evidences of empyema became prominent. This was confirmed on July 21 by aspiration of the right posterior chest wall. Bacteriologic examination of the thick yellow material aspirated revealed gram-negative and gram-positive cocci with gram-negative bacilli.

On July 22, surgical drainage was accomplished by means of a rib resection under local infiltration anesthetic. Within twenty-four hours a left-sided wristdrop was noted. This condition was relieved within four weeks following the application of a cock-up plaster splint. A slight cough persisted and under daily irrigations of Dakin's solution the cavity gradually closed. When the cavity contained only about 30 cc. of fluid, an x-ray examination was made injecting lipiodol into the empyema cavity. This revealed a broncho-pleurocutaneous fistula.

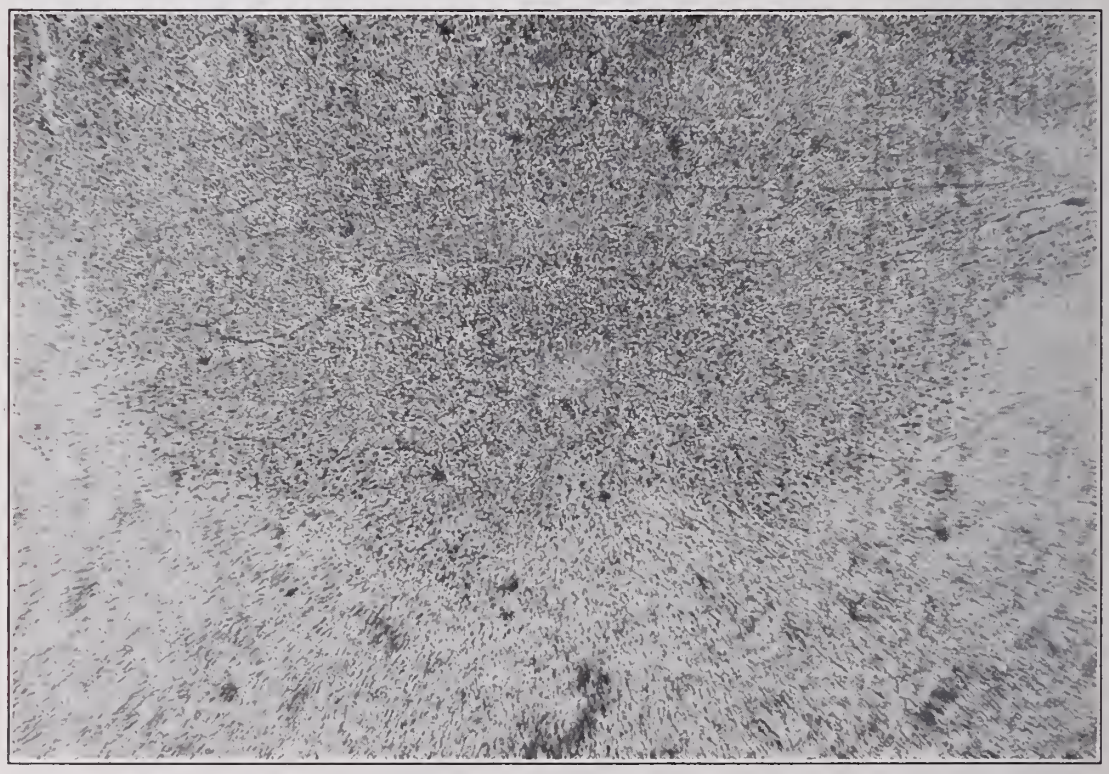


Fig. 3. Margin of hemorrhagic infarct under capsule.

The patient continued to improve and was dismissed from the hospital on September 7, following which treatment was given at my office. The cavity closed within one month, and shortly before closure a footdrop involving the right foot was noted. This, as well as the previous wristdrop, was apparently a toxic manifestation, and although the wristdrop was short-lived, the lower extremity proved very stubborn to treatment. A spring shoe device was fitted, and vitamin B therapy and physical therapy were instituted. By November 20, improvement was such that the patient was able to resume his duties, and by June 8, 1940, the evidences of peroneal nerve paralysis had completely disappeared.

The pathologic findings were as follows: Grossly the spleen measured 15 cm. long, 8 cm. wide, and 3.5 cm. deep. The capsule over the lateral surface had been dissected by a recent hemorrhage which seemed to have taken place at the lower pole. However, the point of the hemorrhage was not obvious. The cut surface was homogenous except for a small gray area in the pulp at the pole. Under the capsule on the medial surface was a small zone of hemorrhage which had penetrated through the capsule.

Microscopically, the splenic pulp exhibited a generally congested appearance. The follicles were uniform, densely cellular and compact. Within the pulp were scattered minute areas of hemorrhage. Some portions of the pulp exhibited moderate leukocytic infiltration. Trabecular arteries occasionally contained fragments of cellular thrombi composed mostly of leukocytes, while in other blood vessels there was more definite evidence of clot formation. In one section extension of the hemorrhage and leukocytic exudate to the surface of the spleen merging with the subcapsular hemorrhage was identified. Several small areas of hemorrhage were identified, and from their pattern there was a suggestion of aneurysmal dilatation of the splenic vessels.

Among the most interesting findings in this spleen were the formation of mural thrombi in the larger trabecular arteries. There was a moderate degree of arteriosclerosis in the splenic arteries, some of which exhibited considerable hyalinization. There was great difficulty in determining whether the splenic arteries alone were involved or whether there is also thrombosis of the small splenic veins.

While these findings presented evidences of recent extensive physiologic changes in the splenic structure due to embolic phenomena in the intrinsic vascular system, there were no pathologic cellular changes of the splenic structures per se. It is logical to deduct, therefore, that prior to this acute episode the spleen was a normal organ and that the rupture was brought about by an acute physiologic disease; that is, acute congestion due to embolic vascular phenomena.

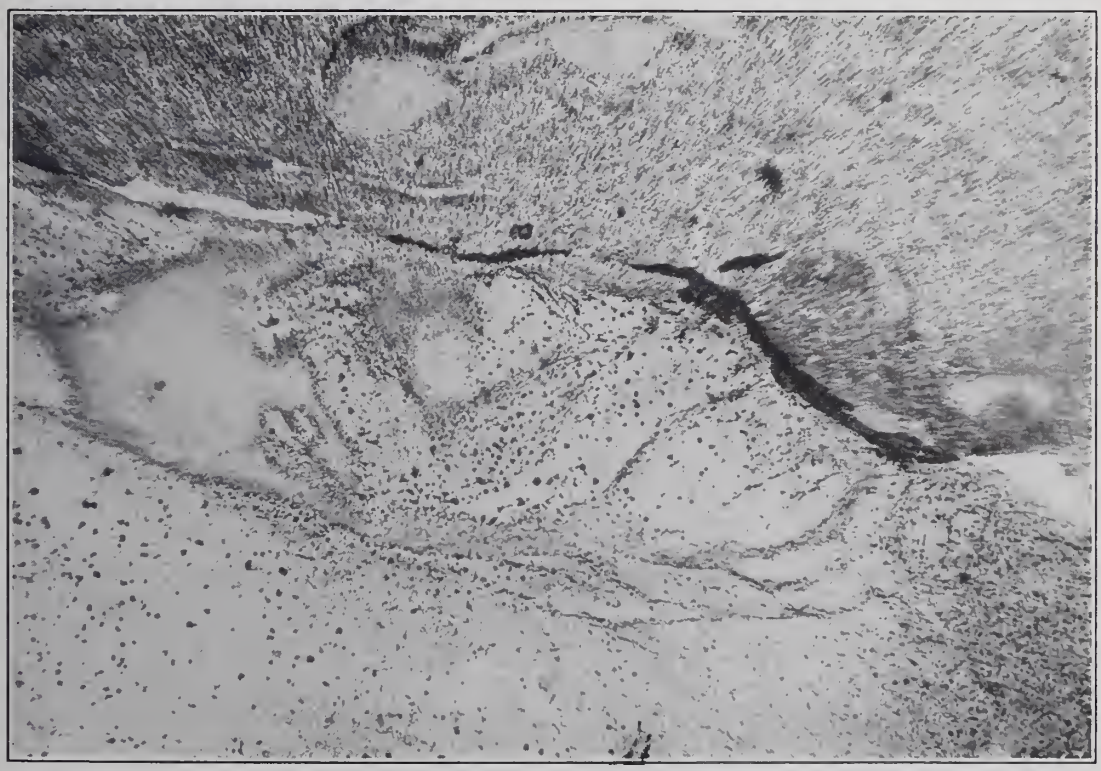


Fig. 4. Hemorrhage under capsule at border of infarct.

Discussion

The most logical explanation that can be offered for the series of events that transpired in this case is as follows: The initial knee injury was trivial in character and was well along in the process of healing when a second trauma added further injury to an area of already lowered resistance, therefore predisposing to infection which at first failed to localize and was diffuse in nature. One can only prognosticate that if suppuration from a localized focus in the knee would have occurred early, the series of pyoembolic phenomena would not have followed. As it was, the infection was of the diffuse phlegmonous type, which predisposed to hematogenic dissemination through the local large veins in the region of the knee. The first embolus apparently lodged in the spleen, producing vascular embolic phenomena within that organ. The increased intrasplenic tension resulted, and subsequently the splenic capsule, which was stretched beyond its capacity, ruptured to release the acute splenic congestion which was the result of the vascular pyogenic emboli.

Whether the postoperative pneumonia was superimposed upon a previous pulmonary infarction, and thus presented another embolic phenomenon, can only be supposed. It is a likely supposition, however, since chest pain and pleuritic pain with the presence of a pleural friction rub was a prominent feature in the onset of the pneumonia. This is not the usual course of a simple postoperative pneumonia, and is more suggestive of a pulmonary infarction.

The complication of empyema is not very common either with type XVIII pneumococcic pneumonia or postoperative pneumonia and lends further circumstantial evidence of probable embolic infarction of the lung previous to the pneumonia. The discovery of cocci in the chest fluid, the same organism of the knee infection, and the absence of pneumococci adds further evidence. Three negative blood cultures do not necessarily contradict this explanation. The development of a broncho-pleural fistula is also a more common finding in pyogenic than in pneumococcic diseases of the lung. The localization of the pus about the knee injury which was late in draining and localizing put an end to the embolic phenomenon.

The medicolegal aspect of this case is interesting. The patient sustained a minor injury and subsequently developed very serious sequellae which led to prolonged and expensive hospitalization, as well as expensive medical and surgical care. The condition very easily could have led to permanent invalidism or death. Since the series of events from the time of the initial injury were fairly clear on the basis of embolic phenomena, it became apparent that the entire train of events would come under our compensation laws making this clinical picture a compensable one.

In so far as permanent disability evaluation is concerned, it is interesting to note that this patient was last examined on August 31, 1940, at which time a complete blood study was made. This revealed no evidence of what the tests tell us we can expect following splenectomy; that is, there was no evidence of a polymorphonuclear leukocytosis, no reduction of red blood cells or hemoglobin, no relative lymphocytosis, and no change in the number of platelets. The findings were entirely normal. He appeared in excellent health and was well able to perform his usual duties without any apparent reduction in capacity for work or reduction of resistance to ordinary colds, etc.

All the above factors lead to the belief that a complete recovery without any permanent disability is not above the realm of possibility in this type of clinical picture. However, disability has been allowed in the European literature, and this varies from no permanent disability to as high as 40 to 60 per cent.

This case represents, in my opinion, the first one in which nontraumatic, nonchronic pathologic rupture of the spleen was related directly to an industrial injury, and it is possible that in the future other similar conditions will come under the scope of industrial medicine and surgery.

(Continued on page 518)

The Prevalence of Venereal Diseases in Wisconsin

By MILTON TRAUTMANN, M. D.*
Madison

SUFFICIENT time has elapsed since the papers of Lorenz[1] and Guilford[2] to reconsider the question of the prevalence of syphilis in Wisconsin. Since these papers, expanded activities in venereal disease prevention have been organized in the State Board of Health. The changes in this field in Wisconsin since 1936 might be stated as follows:

1. Passage and operation of the improved "marriage law" which requires a certificate of freedom from all venereal diseases from the male and a negative blood test for syphilis from both male and female.
2. Placing the administration of the venereal disease program in the hands of a physician in the department of communicable diseases of the State Board of Health.
3. Organization under a physician of venereal disease activities in the Milwaukee City Health department.
4. Revision of the old report forms for venereal diseases.
5. Expansion of state clinic facilities for the care of the indigent.
6. Wider extension of case finding and case holding services by trained public health nurses to the physicians in private practice.
7. Studies of the prevalence of syphilis by Wassermann surveys.
8. Enlarged educational programs.
9. Advent of the sulfonamide group of drugs for the treatment of gonorrhea.
10. More liberal distribution of antisyphilitic drugs.
11. The Wassermann testing of selectees under the Selective Service Act.
12. The organization and conducting of a venereal disease prevention program in August, 1940, in connection with the maneuvers of the National Guard at Camp McCoy.

Syphilis under treatment in Wisconsin is preponderantly late syphilis (see figures on following pages). The relative paucity of primary and secondary syphilis in clinic and private practice is evident and coincides with word-of-mouth experience throughout the state. The similar configuration speaks well, we hope, for the diagnostic acumen of the physician who occasionally treats syphilis as compared with the physicians conducting the state clinics whose experience with many patients makes them specialists. The question might also arise whether with the large number of cases of asymptomatic syphilis of less than four years' duration, an appreciable number of cases of primary and secondary syphilis with mild manifestations are escaping detection.

In considering this question reference to Hansmann's deductions from his pathologic studies is in order.[3] He deduces that in Milwaukee 1.2 per cent of the mothers in the age group up to 35 years have syphilis, that perhaps 369 children out of 123,000 have congenital syphilis (0.3 per cent), and that 12 per cent of the 60-year age group have active or latent syphilis.

Since this paper appeared there has been conducted by the Milwaukee City Health Department with federal funds a continuing voluntary Wassermann testing program in industrial plants and mercantile establishments. Of a total of 32,503 Wassermann tests 544 (1.66 per cent) were positive. These tests represent all age groups, but the patients were predominantly between 20 and 50. When the colored group is removed, the percentage is 1.4. This experience approximates Hansmann's calculation.

Yet it should not be forgotten that this same survey has revealed a prevalence of 15.2 per cent in the colored population in Milwaukee. We should be alert to take all steps necessary to minimize this reservoir of infection in the colored populations of our cities.

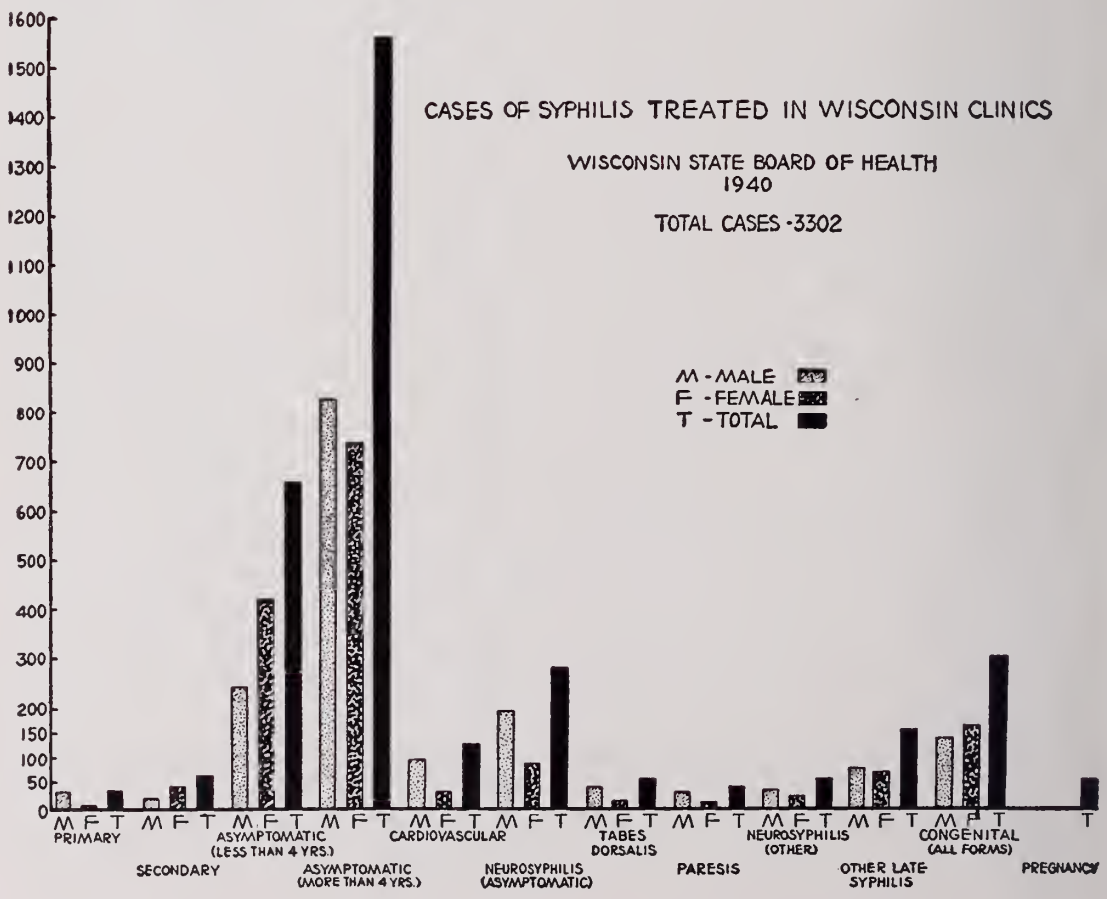
It is not the purpose of this paper to prove a point, but to present facts on record. The difficulties inherent in a statistical estimation of the quantity of any disease prevailing at a given period of time are readily appreciated by men of experience. These

* From the State of Wisconsin Board of Health, Madison.

difficulties are even greater in the case of the venereal diseases because of their nature and usual modes of dissemination. We cannot vouch for the completeness of reporting, for the unerring diagnosis, for the exactness of classification, but believe that the pattern illustrated in the figures below is reasonably accurate. Certainly it represents a composite of clinical acumen in this state. The coincidence of the patterns would lend a strong suspicion of reliability to the data. Reference to the two figures will show the close conformity of the patterns by stage of disease in both clinic and private practice. These also show clearly the low prevalence of the primary and secondary lesions and the preponderance of later syphilis.

One might question whether, perhaps, the clinician is sufficiently on the alert to recognize early atypical cases which later become manifest by Wassermann tests and whether the result of a Wassermann test is too closely relied upon for making the diagnosis. Certainly these errors do occur since we are but human. But the same pattern prevails in the state clinics where we are expecting a higher degree of diagnostic acumen by virtue of the fact that the clinicians in charge have been at the job for many years and in general are held in high regard by the profession.

We should be satisfied therefore, in believing that the physician in practice is not getting many early lesions. The case load under treatment appears to be one of an earlier generation than the one appearing. This is substantiated by the low prevalence of venereal disease in the draftees of this state as compared with the prevalence in other states, Wisconsin being second lowest among the states in this respect. The rate by April, 1940, was 7 in each 1,000 draftees examined. By December, 1941, the records in the State Board of Health showed a total of 92,651 Wassermann tests done of which



436 were positive and 31 doubtful. This is a rate of about 5 cases in each 1,000 examined.

Table 1 shows the cases of syphilis admitted to the three state syphilis clinics in Milwaukee and the low incidence of the early lesions of the disease and the predominance of late forms.

TABLE 1

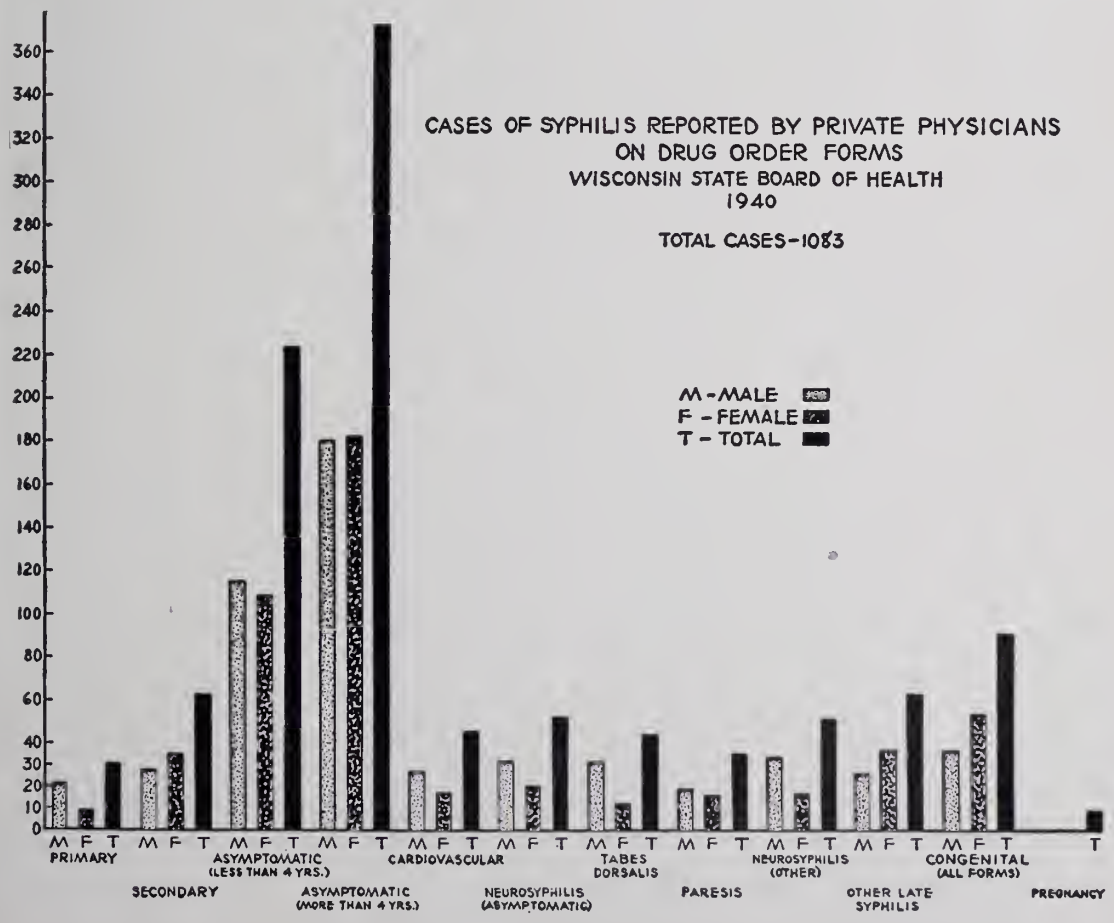
PATIENTS WITH SYPHILIS ADMITTED TO THREE STATE SYPHILIS CLINICS IN MILWAUKEE

September, 1940, through September, 1941, (13 months)

Diagnosis by Stage of Disease	Number Admitted	Percentage of Total Admitted
Primary	6	1.4
Secondary	8	1.8
Latent (under 4 years)	61	13.8
Latent (over 4 years)	252	57.1
Late (cardiac)	18	4.1
Late (central nervous system)	61	13.8
Late (other)	11	2.5
Congenital	24	5.5
Total	441	100.0

Table 2 shows the number of cases of chancre and secondary syphilis appearing in state and private syphilis clinics in 1938. These clinics are all active and embraced a patient population of above 3,500. The low prevalence of these lesions is strikingly evident. It is to be noticed that five clinics went through the year without a record of a primary lesion.

Have venereal diseases decreased in number in the State of Wisconsin? Reference to Table 3 would indicate a decline in gonorrhea but a rather constant number of cases of syphilis and physicians reporting cases. The increase in cases of syphilis reported since 1937 represents, we believe, the effect of our increased state-wide efforts. This increase undoubtedly is relative and not actual, as far as the burden of syphilis in the state is concerned. It represents a generation still in the process of cure. Sometime soon a sud-



den drop will appear if present efforts continue.

It is seen that the decline in cases of gonorrhea reported began shortly before the advent of the sulfonamide group of drugs which now are so effective in treatment. Why this anomalous situation between the two diseases, one holding steady, the other on the decline? The natural history of syphilis as opposed to gonorrhea is a factor and without a doubt the newer remedies are also.

What about the prevalence of venereal disease in Wisconsin as compared to neighbor states? Table 4 throws light upon this question, showing a favorable state of affairs as far as Wisconsin is concerned. This may be a reflection of the law which requires the reporting of only infectious cases of these diseases as compared to neighbor states whose reporting laws are more inclusive.

TABLE 2

CLINIC CASES—SYPHILIS—1938

Patients Admitted With Chancre

Clinic	Male	Female
Mount Sinai Dispensary, Milwaukee	0	0
Janesville	0	0
Kenosha	1	0
La Crosse	0	0
Superior	0	0
Milwaukee County Dispensary	22	12
Wausau	2	0
Oshkosh	5	2
Beloit	0	0
Madison	1	0
Milwaukee City Dispensary	0	0
Racine	1	0
St. Joseph's Annex	0	0
Total	32	14
Total number of chancre cases	46	

Patients Admitted With Secondary Syphilis

Clinic	Male	Female
Mount Sinai Dispensary, Milwaukee	0	1
Janesville	0	0
Kenosha	1	3
La Crosse	8	5
Superior	0	0
Milwaukee County Dispensary	9	4
Wausau	7	4
Oshkosh	10	6
Beloit	0	0
Madison	1	2
Milwaukee City Dispensary	0	0
Racine	0	1
St. Joseph's Annex	0	0
Total	36	26
Total number of secondary syphilis cases	62	

The only city of the first class in population in Wisconsin is Milwaukee. What information have we bearing upon the prevalence of venereal diseases in that city? Table 5 shows Milwaukee reporting about one-third of all cases of early syphilis, about one-fourth of all congenital syphilis, and above one-half of all forms of syphilis. Here again enter such factors as the completeness of reporting in urban as compared to rural areas, and the effectiveness of public health measures in well organized urban as opposed to rural areas not well organized.

As for gonorrhea, the rate in Milwaukee as compared to the rest of the state is about the same.

Undoubtedly a very good index of the prevalence of syphilitic infection is shown by the results of Wassermann tests done for marriage and for induction into the army under the Selective Service Act. These groups represent the ages when infection is acquired and when it is most prevalent. In the case of marriage applicants the rate has been about 8 in each 1,000 and in selectees the rate on December 1, 1941, was 5 in each 1,000 examined.

Syphilis in our Wisconsin Indian population is of interest, and we are inclined to think that the prevalence of the disease in this group is not what many would like to believe. A Wassermann survey of 150 Oneidas in 1938 showed 5 with a positive reaction, of which 2 were congenital (3.3 per cent). A Wassermann survey of the Chippewas in 1941 showed 21 positive reactions and 5 doubtful, 1 in 249 or 8.5 per cent. These are small samples, however, and not sufficiently significant to justify conclusions about the prevalence of syphilis in this group.

What about congenital syphilis? Table 7 shows the results of a questionnaire submitted to practicing physicians and institutions in 1938 which lead one to think that 800 cases might be a liberal estimate of cases of this kind under medical care. Table 5, showing the low number of new cases reported, might belie this conclusion, yet remember that only infectious syphilis is reportable in Wisconsin. Consequently reporting of congenital syphilis is not complete.

Last of all, brief reference should be made, particularly in these days of war, to the question of how effective coordinated official action can be in preventing these diseases. In connection with the maneuvers of 60,000 National Guard troops in Sparta in August, 1940, the coordinated efforts of several state agencies[4] with local civil authorities resulted in the complete discouragement of large scale commercial vice, as a result of which only 4 new cases of gonorrhea developed in the troops and no cases of syphilis.

Lest the impression be obtained that this paper is intended to give a feeling of relaxation or complaisance, let it be remembered that these diseases, though low in prevalence in Wisconsin as compared to other states, are, and always will be, a public problem. A statement appearing in a supplement to Madison newspapers on the occasion of the centennial anniversary of the State Medical Society of Wisconsin says that "this (venereal diseases) is not an acute problem in Wisconsin since for *many years syphilis has been virtually non-existent.*"[5, 6] The fact that typhoid fever and diphtheria are virtually non-existent in Wisconsin still means that they are problems, potentially, and therefore acute in a very real sense, even under the best of control. Certainly if 1,429 cases of gonorrhea and 1,500 cases of syphilis were reported in the state in 1940 we can hardly call venereal diseases virtually non-existent. Indeed, when we consider the potential damage to health and welfare of these diseases one can only conclude that they not only exist but are still acute problems. Without a doubt, they will always remain, regardless of how low their prevalence, both acute and prevalent.

Summary

1. Primary and secondary lesions of syphilis are relatively scarce in Wisconsin. The syphilitic population of Wisconsin is largely afflicted with later syphilis undergoing treatment. However, a large number of such patients are constantly under medical treatment.

2. Wisconsin's rates for gonorrhea and syphilis are lower than those of its neighbor states, which may be partly due to the peculiarity of her reporting law which is not so inclusive.

3. Reservoirs of infection requiring special attention because of the higher preval-

TABLE 3

VENEREAL DISEASES REPORTED TO STATE BOARD OF HEALTH

Year	Number of Physicians Reporting	Cases Reported		New Cases Admitted to State Clinics		Physician Population	Population of State
		Gonorrhea	Syphilis	Gonorrhea	Syphilis		
1919	636	2,445	396				
1920	745	3,150	644				2,632,067
1921	583	2,465	471				
1922	545	2,510	527			2,750	
1923	526	2,360	452	586	802	2,770	
1924	487	2,360	435	703	900		
1925	506	2,598	536	1,140	1,375		
1926	501	2,542	590	755	1,247		
1927	496	2,526	520	1,197	768		
1928	464	2,282	437	1,022	717		
1929	437	2,104	475	694	998		
1930	430	1,878	445	739	819		2,939,006
1931	509	1,944	489	792	908		
1932	465	1,767	440	675	869		
1933	651	2,097	359	601	652		
1934	683	1,891	392	539	626		
1935	651	1,756	317	476	520		
1936	636	1,672	286	415	436		
1937	644	1,720	448	324	552		
1938	637	1,372	505	372	746		
1939	638	1,429	679	381	991	3,523	
1940	579	1,044	1,500				3,137,587
1941		875	1,050				

TABLE 4

RATES PER 10,000 POPULATION

From United States Public Health Service Monthly Morbidity Report

Month	Year	Syphilis—All Forms					Gonorrhea—All Forms				
		Wis.	Iowa	Minn.	Ill.	Mich.	Wis.	Iowa	Minn.	Ill.	Mich.
January	1940	.18	1.04	.82	2.47	--------	.29	.66	.64	1.43	--------
February	1940	.67	--------	.80	2.15	1.48	.16	--------	.86	1.30	1.02
March	1940	.31	1.04	1.67	2.48	1.13	.25	.49	.64	1.58	1.17
April	1940	.40	--------	.87	2.31	2.01	.17	--------	.51	1.63	1.07
May	1940	.55	.77	.83	2.56	--------	.23	.50	.63	1.72	--------
June	1940	.55	.66	.92	2.27	1.64	.35	.43	.69	1.75	1.12
July	1940	.41	1.00	.81	2.44	1.77	.30	.69	.68	2.11	1.44
August	1940	.51	.80	1.00	2.29	1.37	.42	.59	.97	2.11	1.29
September	1940	.41	.82	.73	2.06	.93	.36	.68	.67	2.10	1.53
October	1940	.37	.87	.80	2.50	1.56	.37	.60	.47	2.32	1.54
November	1940	.23	.85	.69	2.25	1.30	.21	.45	.52	2.04	1.16
December	1940	.42	.81	.66	2.01	1.58	.34	.41	.58	1.79	1.25
January	1941	.26	1.25	.50	2.17	1.22	.19	.56	.43	1.91	.96
February	1941	.29	.72	.82	1.95	.80	.19	.46	.41	1.61	1.21
March	1941	.21	.82	.75	2.15	1.48	.31	.37	.47	1.77	.93
April	1941	.26	1.01	.83	2.57	1.46	.27	.45	.47	1.74	.95
May	1941	.27	.73	.85	2.80	2.39	.22	.39	.42	1.90	1.66
June	1941	.29	.53	.76	2.84	1.82	.20	.39	.42	2.00	1.37
July	1941	.39	.71	.80	2.82	2.07	.23	.46	.56	2.23	1.61

TABLE 5

NEW CASES OF SYPHILIS REPORTED TO STATE BOARD OF HEALTH

From United States Public Health Service Monthly Morbidity Reports

Month	Year	Primary and Secondary Syphilis		Congenital Syphilis		All Forms	
		Wisconsin	Milwaukee	Wisconsin	Milwaukee	Wisconsin	Milwaukee
January	1940	10	3	0	2	53	12
February	1940	29	7	3	0	196	138
March	1940	7	2	4	1	91	60
April	1940	0	0	7	0	117	64
May	1940	8	1	5	0	161	70
June	1940	17	5	6	2	161	69
July	1940	40	14	5	2	121	48
August	1940	16	11	8	1	151	66
September	1940	20	5	4	1	127	61
October	1940	12	6	2	0	116	45
November	1940	27	1	1	0	73	12
December	1940	47	23	1	0	133	83
January	1941	11	4	1	1	81	35
February	1941	4	2	3	3	92	45
March	1941	12	No Report	6	No Report	65	No Report
April	1941	19	No Report	2	No Report	82	No Report
May	1941	17	No Report	1	No Report	69	No Report
June	1941	15	9	2	3	91	49
July	1941	20	4	1	0	122	87
Total	--------	331	97	62	16	2,102	944

TABLE 6

NEW CASES OF GONORRHEA REPORTED TO STATE BOARD OF HEALTH

From United States Public Health Service Monthly Morbidity Report

Month	Year	Wisconsin	Milwaukee	Rate per 10,000 population	
				Wisconsin	Milwaukee
January	1940	85	15	.29	.24
February	1940	48	14	.16	.22
March	1940	75	18	.25	.29
April	1940	50	17	.17	.27
May	1940	67	7	.23	.11
June	1940	104	20	.35	.32
July	1940	87	12	.30	.19
August	1940	124	29	.42	.46
September	1940	114	28	.36	.47
October	1940	116	27	.37	.46
November	1940	67	10	.21	.17
December	1940	107	25	.34	.43
January	1941	59	14	.19	.24
February	1941	59	15	.10	.26
March	1940	96	----------	.31	----------
April	1941	86	----------	.27	----------
May	1941	69	----------	.22	----------
June	1941	62	6	.20	.10
July	1941	72	16	.23	.27

ence of venereal diseases in those groups are the colored population of some of our cities.

4. A very decided decline is occurring in the prevalence of gonorrhea.

5. On December 1, 1941, the prevalence of syphilis in the age group, male, being drafted into the army was 5 in each 1,000.

6. Patients with congenital syphilis being treated in the state of Wisconsin probably total 800 or 1,000.

7. The concerted efforts of the last five years in venereal disease control are uncovering much previously hidden disease.

8. It was demonstrated in the National Guard maneuvers at Sparta in 1940 that local official agencies can be organized effectively and coordinated in order to secure suppression of commercialized prostitution.

9. Last but not least, venereal diseases are acute problems and prevalent in Wisconsin.

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TABLE 7

CONGENITAL SYPHILIS IN WISCONSIN—1938 STATE BOARD OF HEALTH

Results of a questionnaire submitted to practicing physicians and institutions asking how many cases of congenital syphilis were under treatment

Questionnaires issued	2,500
Total replies received	1,318
Replied "no cases"	1,143
Replied, giving cases	175
Number of cases reported	
From institutions	61
From private physicians	334
From state venereal disease clinics	149
Total	544

CONSTANT VIGILANCE

Wisconsin's enviable record of only seven deaths from diphtheria in 1941 can be maintained only if there is constant vigilance on the part of physicians in urging mothers to have their children immunized during the first year of life.

Comments on Treatment

Editor—A. J. QUICK, M. D., Marquette University, Milwaukee

Palliative Treatment of Trigeminal Neuralgia

Treatment to control the pain in trigeminal neuralgia or tic douloureux continues to be a subject of great interest and importance. Unfortunately no permanent cure other than the division of the sensory root of the gasserian ganglion is known. By means of palliative treatment, surgical treatment can often be delayed several months or even longer, and curiously in a few cases permanency of relief has been reported. The cause of trigeminal neuralgia is not known and therefore all therapy except radical surgery is empirical. Any new suggestions regarding this disease are highly welcome.

The observations of Dr. Poser are very interesting and merit attention and further study. In addition to Dr. Poser's contribution, it seems advisable to give a short summary of the use of trichloroethylene which has been employed successfully during the last two decades. A. J. Q.

Nicotinic Acid and Trigeminal Neuralgia

The observation that drafts, cold air or any cooling process may bring on an attack of trigeminal neuralgia is not uncommon. Equally true is the fact that heat may act beneficially toward relieving paroxysms of pain. Certain drugs that have a dilating action on blood vessels also act favorably while other drugs which cause constriction may act detrimentally. Therefore ischemia seems to have a definite relationship to this pain. The trigeminal receives its blood supply from the internal carotid artery. Apparently whatever causes the constriction of this blood supply may help produce the attack of pain.

Various vitamins, especially vitamin B_1, have been suggested practically ever since their discovery, but this therapy has not proven very effective. However, nicotinic acid, a strong blood vessel dilator, has been used with more success. When taken in sufficient quantity on an empty stomach, the dilating action of nicotinic acid may be easily recognized by the flushing and tingling of the ears, face, scalp, neck, and sometimes the body.

In view of this fact, nicotinic acid was administered to a girl, aged 20, who developed trigeminal neuralgia coincidentally with an abscessed tooth. The pain persisted after the removal of the tooth and did not respond to heat or vitamin B_1. With 100 mg. of nicotinic acid, complete relief was obtained and this abolition of pain was repeatedly noted by this patient following the administration of the vitamin.

In another patient, a man of 80, who had as many as twenty-five to thirty-five paroxysms of severe pain, nicotinic acid (50 mg.) did decrease the severity of the attacks, but not the number of paroxysms. Apparently when the vessels are sclerotic and incapable of dilating, nicotinic acid is relatively ineffective.—Eduard F. Poser, M. D., Columbus.

Trichloroethylene

It is a peculiar fact that trichloroethylene when inhaled produces a loss of sensation bilaterally over the distribution of the fifth cranial nerve. This property of the compound has been utilized for the control of the pain in trigeminal neuralgia. The drug is available in 1 cc. frangible glass vials. To use, one of these is placed in a small container and broken. The patient inhales the vapor until all has evaporated. Occasionally a second vial is necessary. The treatment is repeated as needed and some patients have to inhale the drug three to four times a day for periods of weeks.

Little is known concerning the toxicity of the compound. Its action seems to be fairly specific on the trigeminal nerve. A few transient, disagreeable effects such as giddiness, lassitude, nausea and palpitation are occasionally noted and even temporary toxic psychoses have been reported.

Although no damage to the liver, heart and other organs have been noted in patients using the drug, it is well to remember that the compound is closely related to chloroform. It is therefore not a drug to be used indiscriminately and is definitely too dangerous for self-medication. It is the responsibility of the physician to decide when the drug is to be stopped and permanent cure effected by section of the sensory root of the gasserian ganglion. A. J. Q.

The Nation at War

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

The Record Speaks

"THE moving finger writes; and having writ, moves on,—" and recorded forever in the annals of this country's military efforts is the chapter of the brilliant work of the medical profession in the Hawaiian Islands on December 7, 1941.

Seldom are chronicled our men's heroic deeds as more than statements of fact, unembellished by the emotion which attended the occasion. Seldom do the people acquire a keen appreciation of the difficulties under which heroism is the more outstanding.

But Professor Blake Clark, University of Hawaii, Honolulu, was determined that "Remember Pearl Harbor" should be carried in the history of our country as something more than a motto of the war, and that determination led him, on the morning following the day of infamy, to "get the story." In published form,* it is now available to all who would live, as best they can, the experiences of those at Honolulu.

To those in the medical profession who serve the war needs of their country through participation in Emergency Medical Service in the program of Civilian Defense, there is much of value in this book.

"We learned in Honolulu that Sunday how narrow the dividing line is between the soldier and the civilian in war time. We were inspired by the example of America's courageous soldiers and sailors, and fighting mad at the Japanese invaders for their cowardly attack. We wanted to do something. There was vitally important work to do, and civilians leaped to it.

"Soon after the bombing started, a call came into the headquarters of the Hawaii Medical Association. It just said, 'Pearl Harbor! Ambulances! For God's sake, hurry!'

"This was the challenge that the Medical Corps had been waiting for from the day, months ago, when they first organized. And did they pick it up! Within only twenty minutes from the time the call came, the doctors and volunteer workers of the medical units had stripped the insides of over one hundred laundry trucks, lumber trucks, and delivery trucks of every description, equipped them neatly with previously prepared frames containing room for four litters each, and were speeding to the scene of action. One unit arrived early enough to receive a souvenir piece of shrapnel, flung at them by a Japanese bomb.

"Another call came: 'Department Surgeon King, at Tripler Hospital! Surgical teams, quick!'

"Then occurred one of life's breath-taking coincidences. At that very moment virtually every surgeon in Honolulu was listening to a lecture on war surgery. It was being delivered by Colonel Moorhead, famous authority on the subject. The audience departed in a body for Tripler. In fifteen minutes, more capable surgeons stood ready at Tripler than Surgeon King could use.

"By another coincidence no less fortuitous, they had with them a new surgical instrument which Colonel Moorhead had brought to Honolulu to demonstrate. Its purpose was to locate metal in the body and outline its exact location. The only instrument of its kind in existence, it proved its worth at once that morning. It saved precious hours of time that would have been spent waiting for X-ray pictures to be developed.

"Honolulu morale is high. We have learned that our civilian morale is the result of our preparedness. We see that morale depends upon what goes on before the war hits. The

* *Remember Pearl Harbor!* by Blake Clark. Modern Age Books, New York. Price $1.25.

Hawaii Medical Association is treasuring a telegram from George Baehr, M. D., Chief Medical Officer for Civilian Defense in Washington. It reads:

> "Territorial Medical Association: Office of Civilian Defense requests you urge all hospitals to establish immediately emergency medical field units in accord with plan outlined in Medical division bulletin Nos. 1 and 2 and drill weekly. When necessary, reserve field unit should be organized with Medical G. W. nursing and training volunteer personnel derived from the community. Urge immediate action.

"This telegram arrived just two and one-half days after twenty such units had been in action. To appreciate the preparation it takes to train a complete medical unit, you must know that a single unit consists of two doctors, two dentists, eight nurses, eight surgical aides, eight supply men, one supply clerk, six stenographers, nine utility men, sixty-four litter bearers, two dietitians, two motorcyclists, two messengers, six ambulance drivers, and three ambulances. One hundred and twenty persons in all. When you remember that the Hawaii Medical Association had twenty units, a total of 2400 persons, in the field on the morning of the bombing, you see what a deal of preparation the doctors had made.

"Each one of the 2400 persons who sprang to activity on that December Sunday had received eighty-two hours of instruction. For months busy doctors voluntarily met groups of people in hot schoolrooms after work at night. It was boresome, tiring labor. They had 'dry-runs,' rehearsing an emergency, pushing ambulances out, carrying each other around on stretchers, and wrapping each other up in bandages. All this shadow-play seemed foolish to people looking on from the outside who did not think there was going to be any emergency anyway.

"But on Sunday, their preparation gave spirit to the rest of us and, in many cases, an outlet to our own energies."

Does one wonder that Colonel Moorhead (professor of clinical surgery, New York Post-Graduate Medical School, Columbia University) spoke these simple words of tribute to the doctors in Honolulu: "The United States of America owes you, the civilian doctors of Honolulu, a debt of gratitude for the work you did on December 7."

THE WISCONSIN COUNCIL OF DEFENSE REORGANIZES

The Wisconsin Council of Defense, under the direction of Mr. R. S. Kingsley, Kenosha, as chairman, recently has perfected a reorganization to bring the machinery of civilian defense operations in Wisconsin in line with those being followed nationally. Of particular interest to physicians is the fact that the activities of the Wisconsin Council of Defense fall into four separate sections—the defense corps, the service corps, the auxiliary, and the air patrol. Emergency Medical Service comes under the direction of the commander of the defense corps who, on the state level, is Captain L. F. Thurwachter, Waukesha.

Bracketed in the defense corps are the activities of fire service, police service, air raid service, highway and public works protection, and emergency utility service, in addition to Emergency Medical Service. Each of the six divisions is under the direction of a state chief, and the state chiefs act as an advisory staff to Captain Thurwachter as commander of the defense corps.

The chairman of Emergency Medical Service is Dr. R. E. Fitzgerald, Wauwatosa, who held that position under the previous organization.

The service corps organization is under the supervision of an executive director, and in the service corps are now included such affiliated services as health, welfare, nutrition and housing.

The organization of Civilian Defense in Wisconsin is proceeding rapidly and satisfactorily, and with the streamlining of the Wisconsin Council of Defense it is anticipated that each of the various county councils will duplicate its organization so that all councils of defense in Wisconsin and in other states will be in complete uniformity with the organization of the Office of Civilian Defense under the direction of Mr. James M. Landis.

First Wisconsin Mobile Casualty Station

EMERGENCY Medical Service of Racine County claims the distinction of possessing the first mobile casualty station in Wisconsin. Through the civic generosity of Mr. H. F. Johnson, president of S. C. Johnson & Son, Inc., Racine, the traveling unit pictured above was donated to the cause of Civilian Defense for the duration of the war. With its base in Racine, it will serve a radius of 150 miles.

The unit was especially constructed in 1940 to serve S. C. Johnson & Son, Inc. as a field laboratory in its experimental and research activities in behalf of the company's production of wax and paints. Built to design, it is 23½ feet long, has a Mercury motor with front wheel drive, carries its own supply of water, and is equipped with sleeping bunks for three persons, bathroom, gas refrigerator, stove, and ample storage room.

Assigned to the casualty station will be a driver who will be available upon call. The unit contains standard pharmaceutical, surgical, and medical supplies as required by the Office of Civilian Defense for casualty station units under Emergency Medical Service.

Mr. Johnson has permitted the unit with its casualty supplies to be shown throughout Wisconsin to county chiefs of Emergency Medical Service and to others interested in Civilian Defense, and it has already traveled nearly 2,000 miles. Displayed by the State Medical Society in cooperation with the Wisconsin Council of Defense, of which Mr. R. S. Kingsley, Kenosha, is chairman, and Mr. Seth Pollard, Waukesha, is executive secretary, the mobile casualty station serves as a firsthand demonstration of the equipment needed for an emergency. Besides the necessary equipment for a casualty station, it has a protective awning, table, splints, and stretchers.

The unit has been accompanied by representatives of the State Medical Society, and during its first tour was available for inspection by the county chiefs of Emergency Medical Service in thirty-five of Wisconsin's seventy-one counties. The unit was also on display during the War Sessions of the American College of Surgeons in Madison the early part of May.

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Annual Subscription ---------- Three Dollars-Fifty Cents Single Copies ---------- Fifty Cents

Advertising Representative: Cooperative Medical Advertising Bureau, 535 North Dearborn St., Chicago, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, Madison

Volume 41 — JUNE, 1942 — Number 6

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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« « « EDITORIAL » » »

On the Waiting Room Table

THE lay public frequently thinks of the physician as one who is called upon only in time of illness or accident to alleviate pain and suffering and promote the patient's health. The services of the profession are available, however, in countless ways for the promotion and the protection of the public health. Accompanying this issue of *The Journal* is a special supplement for the use of physicians and laity, comprising reprints of the various articles which have appeared since the first of the year relative to Wisconsin food products in the national health.

In the December, 1941 issue of *The Wisconsin Medical Journal* we stated that "the men of medicine will, as they have done since time immemorial, bring to the citizenry the benefits of their scientific knowledge, and make available in increasing quantity and high quality the services of the medical man."

The medical profession of Wisconsin felt that through the medium of these articles on "blessings of the table" the Wisconsin medical profession could emphasize to the profession and laity alike that these foods are truly among our first lines of defense and that they will always continue to be bulwarks of ultimate peace and national tranquility.

Let the physicians of Wisconsin use the reprints of these articles on their waiting room tables and in their talks before public groups and elsewhere where they may serve their intended purpose. Additional copies may be secured at printer's cost from the Medical Society office.

. . . . THE PRESIDENT'S PAGE . . . .

Making Use of Our Facilities

"OPPORTUNITY for service" is the keynote which impels most of us to take up the duties of our profession. Opportunity for financial reward is so slight that if this were the motivating force in our selection of a life calling, men of medicine would be making a poor choice indeed. True, the average successful member of our profession usually is rewarded with sufficient compensation to maintain a respectable and dignified standard of living. This is as it should be.

Due to the semipublic nature of his work and the personal and intimate contact the physician makes with all strata of society, the public at large has, or feels that it has, a vested interest in the medical man of the community. So often is he called upon to do work without thought of financial reward that responding to a call for service whenever and wherever the occasion arises has become an integral part of the make-up of the true physician.

The physician is always in the picture whenever a welfare organization or public "uplift" group gets together to cultivate its particular sphere of interest. There are special groups which would aid the blind; others that are particularly concerned with the hard of hearing. The efforts of some go to help the crippled child, while others center their attention on those afflicted with tuberculosis. The delinquents of all types, especially those who find it difficult to adjust themselves to their environment in organized society, have their solicitous friends. Requests for help from these groups result in extra duties imposed upon physicians generally and are all in addition to those which arise as a result of the war effort, duties in connection with Selective Service, local draft boards, etc.—all receiving services which are gladly given without thoughtof remuneration.

There is not a single group of this type which does not expect to, and as a matter of fact does, lean upon the profession for help. If a lay organization is able to secure gratis service by a physician or group of physicians, the credit not infrequently goes to the group which secures the services and not to the ones who actually render the work.

If a medical man, who in his mature judgment is somewhat reserved and hesitant when appealed to by some overenthusiastic lay reformer or "uplifter," wishes to weigh the problem in question in the light of other related problems in order to arrive at a sober conclusion based upon the relative merit of the project at hand, and if this medical man does not immediately embrace the suggestion vigorously and unqualifiedly and becomes an enthusiastic proponent for it, he, as well as the entire profession, is often stamped as being opposed to progress, indifferent, reactionary, and apathetic to matters of great public concern. From misguided lay enthusiasts such accusations have become a commonplace in the last generation.

Occasionally in responding to requests made upon us, we may by some statement or act say or do something which is mistakenly interpreted as representing the official attitude of medicine generally, so that refusal to cooperate by one man or a small group may be construed as the accepted policy of the profession at large. As a result of such a hurried or ill-advised act, the entire profession may sometimes suffer and it may take months or even years to right or clarify a situation which developed more or less by reason of a purely local inadvertence.

If a situation should develop in which a lay organization makes demands upon a local medical group, particularly where the request may by implication or otherwise involve a question of broad general policy upon which the organized profession already may or may not have declared itself, the part of wisdom would seem clearly to be one of going slow. Do not act hastily! Hasty action resulting in an ill-considered, blunt commitment may prove embarrassing to the local group as well as to medicine generally.

Communicate with your secretary or one of your officers who has ready access to headquarters so that the matter may be given thought and consideration in its relation, if any, to the declared policy of organized medicine. The service of the secretary's office is yours for the asking. He is anxious and willing to be of help. Let's use it to its utmost capacity!

Gunnar Gundersen

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. J. S. Supernaw, Madison, President
Mrs. E. S. Schmidt, Green Bay, President-Elect
Mrs. J. Gurney Taylor, Milwaukee, Vice-President
Mrs. E. H. Townsend, La Crosse, Recording Secretary
Mrs. H. L. Greene, Madison, Corresponding Secretary
Mrs. E. P. Bickler, Milwaukee, Treasurer
Mrs. W. E. Sullivan, Madison, Parliamentarian

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Convention—
Mrs. R. D. Champney, Milwaukee
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Mrs. R. E. Fitzgerald, Wauwatosa
Hygeia—
Mrs. A. C. Taylor, Appleton
Organization—
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Mrs. C. N. Neupert, Madison
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Mrs. Charles Fidler, Milwaukee
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Mrs. H. Kent Tenney, Madison

STATE CONVENTION CHAIRMAN

The president of the Woman's Auxiliary to the State Medical Society of Wisconsin, Mrs. J. S. Supernaw of Madison, is pleased to announce the appointment of Mrs. R. D. Champney of Milwaukee as convention chairman following the resignation of Mrs. Eben J. Carey of Wauwatosa. Mrs. Champney, who has just completed her term of office as president of the Milwaukee County Auxiliary, will announce her committee chairmen and the program for the annual meeting in an early issue of *The Journal.*

Dane

The May meeting of the Woman's Auxiliary to the Dane County Medical Society was held on the eleventh at the home of Mrs. Carl N. Neupert, Madison. Mrs. Garrett A. Cooper, Madison, reports that Mrs. Walter E. Sullivan, chairman of the hostess committee, was assisted by Mmes. Peter A. Duehr, Donald M. Britton, John A. Hurlbut, and Paul A. Brehm. Thirty members and two guests were present.

Mr. Wade Boardman, Madison attorney, discussed emergency housing, urging the physicians' wives to take the lead in opening their homes to defense workers. Mr. Norris E. Maloney, district attorney, gave an informative talk on "Everyday Routine on the Job."

Mrs. Cyrus G. Reznichek, Madison, reported twenty-two members in the Cancer Field Army, and urged the remainder of Dane County Auxiliary members to join soon. The nominating committee was announced as Mrs. Benjamin I. Brindley, chairman, Mrs. W. Homer Krehl, and Mrs. Garrett A. Cooper, all of Madison.

Kenosha

Mrs. Alphonsus M. Rauch, Kenosha, was elected president of the Woman's Auxiliary to the Kenosha County Medical Society on May 5 at the home of Mrs. Leonard M. Rauen, with Mrs. Joseph P. Graves as assisting hostess. Other elected officers are Mrs. Clifford M. Creswell, president-elect; Miss Norabelle Binne, secretary, and Mrs. Joseph P. Graves, treasurer, all of Kenosha.

Committee chairmen for the coming year include Mrs. Leif H. Lokvam, program; Mrs. Edgar F. Andre, hostess; Mrs. Leonard M. Rauen and Mrs. Charles E. Pechous, public relations; Mrs. George C. Schulte, philanthropic; Mrs. Albert J. Randall, telephone; Mrs. Leslie T. Kent, *Hygeia;* Mrs. Walter C. Kleinpell and Mrs. Harry L. Schwartz, press and publicity; Mrs. Charles F. Ulrich, membership; Mrs. Alexander Schlapik and Mrs. Theodore Sokow, ways and means, and Mrs. Alfred L. Mayfield, archives.

The Auxiliary voted to help finance seven Girl Scouts in camp this summer, to contribute hams to the U. S. O. canteen, and to donate $10 to the cancer control fund.

W. W. Vincent, Jr. showed his interesting motion picture "Dad and I Take a Walk," during the social program. Dr. Helen A. Binnie, Kenosha, poured at the tea which followed.

Milwaukee

The tenth luncheon meeting of the Woman's Auxiliary to the Medical Society of Milwaukee County was held at the Schroeder Hotel on May 8. Fifty members attended.

Mrs. Valorus F. Lang asked members to send cakes to the U. S. O. headquarters in Milwaukee, and the response was most gratifying.

The program was arranged by Mrs. Robert E. McDonald. Mmes. Angelo Hoffman, Clarence Slater, Read Widrig and G. Maasen gave a piano duo. After the delightful musical program, Miss Doris Brockway, instructor in home economics at Milwaukee Downer College, spoke on "New Fabrics the War Has Given Us." The topic was timely and much enjoyed.

Mrs. Richard D. Champney, president, called the business meeting to order. The secretary read the minutes of the ninth regular meeting, and the president, treasurer, and auditing committee gave reports. Mrs. Enoch F. Peterson read the history of the year which incorporated information gathered from reports of various committee chairmen.

The following new members were announced: Mmes. John J. Wilkinson, Alvin M. Shapiro, and S. Haushalter. Mrs. William C. Liefert presented Mrs. Champney, retiring president, with a gavel. Mrs. Champney in turn presented Mrs. Harry O. Zurheide, incoming president, with a gavel.

The nominating committee presented the following slate:

Board Members

Mrs. Thomas S. O'Malley (2 years)
Mrs. Sidney J. Silbar (2 years)
Mrs. Irwin Schulz (1 year)
Mrs. Theodore H. Rolfs

Officers

President, Mrs. Francis R. Janney
Vice-president, Mrs. Roland H. Frederick
Recording secretary, Mrs. Edgar J. Behnke
Corresponding secretary, Mrs. David E. W. Wenstrand
Treasurer, Mrs. Jack L. Kinsey

Mrs. William M. Jermain, parliamentarian, read the section of the By-laws pertaining to elections. Since there were no nominations from the floor, the secretary was instructed to cast a unanimous ballot for the above nominees. The meeting was then adjourned.

Outagamie

Twenty-two members and one guest were present at a dinner meeting of the Woman's Auxiliary to the Outagamie County Medical Society at the Candle Glow Tea Room, Appleton, on March 19. Following the dinner members were guests of the Sisters of St. Elizabeth Hospital for their business meeting. Mrs. Robert T. McCarty, president, presided. Committee reports were given by the respective chairmen.

Mrs. Edward J. Zeiss, president-elect, gave an interesting report on the meeting of the Board of Directors held in February, and also on the *Hygeia* project.

Mrs. J. W. MacGregor, of Portage, chairman of the Committee on Nominations, announces that the following members are attending the meeting of the Woman's Auxiliary to the American Medical Association, as delegates from Wisconsin.

Mrs. G. A. Dockery, Franksville
Mrs. W. A. Werrell, Madison
Mrs. R. K. Irvine, Manawa
Mrs. J. C. Sargent, Milwaukee
Mrs. K. L. Puestow, Madison
Mrs. S. A. McCormick, Madison

It was decided that, in keeping with the wartime policy, plans for the open meeting and tea would be canceled this year, and that more effort would be put forth to help Civilian Defense and Red Cross projects. Members offered their services to the Sisters of St. Elizabeth Hospital as hospital aides, and the first meeting was held on April 14.

It was announced that an appeal had come from Dr. John B. MacLaren, chairman, Health and Welfare Section, County Council of Defense, and chief, Emergency Medical Service, for material for bandages. It was further announced that this material could be sent to St. Elizabeth Hospital, where members of the Auxiliary would launder and sterilize it and then make it into bandages.

Racine

Numerous floral pieces, many of them sent by friends for the occasion, contributed to the attractiveness of the new home of Dr. and Mrs. Walter C. Roth, Racine, on April 22. A meeting of the Woman's Auxiliary to the Racine County Medical Society was followed by open house for members of the Medical Society, their wives, and the nursing staffs of St. Mary's and St. Luke's Hospitals.

At the Auxiliary meeting Mrs. Charles E. Constantine reviewed A. J. Cronin's "The Keys of the Kingdom." Assisting hostesses included Mmes. Carl O. Schaefer, Kenneth C. Kehl, Andrew S. Pfeiffer, George L. Ross, and George W. Walter. Mmes. Schaefer and William C. Hanson poured at the tea table. In the absence of Mrs. Raymond D. Jamieson, Mrs. Pfeiffer presided at the meeting, which was attended by thirty members and two guests. About 140 guests gathered later in the game and recreation rooms for a buffet dinner.

Mrs. Henry B. Beeson was hostess to thirty-seven members of the Woman's Auxiliary at a dessert luncheon in her new French Provincial home on May 11. Spring flowers were used for decorations,

and Mmes. Charles F. Browne and Ira F. Thompson poured. Assisting hostesses were Mmes. Albert M. Lindner, Edmund W. Schacht, Henry J. Brehm, Clesson C. Atherton, Richard W. McCracken, and Irenaeus N. Tucker.

During the afternoon Mrs. F. D. Bowers, guest speaker, showed colored slides to illustrate her talk on Mexico.

Rock

The Woman's Auxiliary to the Rock County Medical Society held its April meeting at the Woman's Club on April 28. Following dinner, Dr. Margaret E. Hatfield, Rock County health unit, showed a motion picture sponsored by the American Medical Association, entitled "When Bobby Goes to School." It stressed the importance of pre-school medical examination. Mrs. Ralph C. Hartman, Janesville, was program chairman.

Sheboygan

The *Bulletin* was the source of program material for the meeting of the Woman's Auxiliary to the Sheboygan County Medical Society at the home of Mrs. Alton J. Schmitt on May 6. Mrs. Horace J. Hansen, president, conducted the meeting.

Mrs. Victor F. Neu gave a report on several different articles emphasizing doctors' wives aligning themselves with the Civilian Defense program. Mrs. Leon F. Pauly spoke on "Good Health in Ecuador," and Mrs. Paul B. Mason reported on "Nutrition."

Every member who had not contributed before gave $1 to the cancer fund being raised by the Women's Field Army of the American Society for the Control of Cancer. The Auxiliary voted to give $15 for the purchase of utility kits for the Red Cross.

Mrs. Fred A. Nause was appointed chairman of the nominating committee, with Mrs. William G. Meier and Mrs. John J. Boersma.

Mrs. Meier and Mrs. Joseph F. Kovacic presided at the serving table which was decorated with orchid sweet peas and daisies.

Washington—Ozaukee

The Woman's Auxiliary to the Washington–Ozaukee County Medical Society met on April 9 at the home of Mrs. A. H. C. Carthaus, Thiensville. Members from Ozaukee County were hostesses at a dessert bridge, which was enjoyed by fourteen members and one guest.

Mrs. Clifford H. Kalb, Grafton, entertained the group by reading the play, "The Unseen," by Alice Gerstenberg. Winners in bridge were Mmes. H. Meyer Lynch, West Bend; Frank W. Lehmann, Hartford, and Albion H. Heidner, West Bend.

Twenty-one members and two guests of the Washington–Ozaukee Auxiliary met on May 14 at the home of Mrs. Kilian T. Bauer, West Bend. The guests were Mrs. J. M. Burger, Port Washington, and Mrs. T. D. Elbe, Thiensville. Mrs. Edmound L. Bernhardt, West Bend, joined the Auxiliary at this meeting.

A program of book reviews by Mrs. Robert E. Fitzgerald, Wauwatosa, was the feature of this meeting. Mrs. Fitzgerald, who has been both state and national president, is well known for her book reviews.

Waukesha

The open meeting of the Woman's Auxiliary to the Waukesha County Medical Society was held at the Y. W. C. A., Waukesha, on April 30, with fifteen members and sixty guests in attendance.

Dr. W. W. Bauer, director of the Bureau of Health Education of the American Medical Association, discussed "Women and Wartime Health." He was introduced by the president, Mrs. Traugott H. Nammacher, Oconomowoc.

In answering the question, "What is women's place in the picture?" Dr. Bauer said, "Women have a tremendous influence on the family life. Economically 80 per cent of the nation's income is directed by women, and the health status is almost entirely in the hands of women. Careful study and direction of this responsibility would be a valuable contribution." He also discussed the incidence of heart disease and cancer, nutrition, and wartime morale, and stated that constructive personal contributions are the buying of bonds, Civilian Defense work, Red Cross work, and first aid.

The Auxiliary also sponsored talks by Dr. Bauer before the Oconomowoc High School and the Waukesha High School. The committee on publicity consisted of Mrs. Herbert F. Sydow, Mrs. John S. Giffin, and Miss Hertha Voje.

Winnebago

The great mental strain of war on men in active service was stressed by Dr. Byron J. Hughes, medical superintendent of Winnebago State Hospital, in a talk on April 27 at a luncheon meeting of the Woman's Auxiliary to the Winnebago County Medical Society. Dr. Hughes' talk was an outstanding part of a series the Auxiliary is having on mental hygiene.

The speaker pointed out the steps taken to prevent mental breakdowns in the men who are sent into service. "We have benefited," he said, "by experience of previous wars and we now know that those constitutionally incapable of withstanding the mental and physical strain of warfare must be kept out of combat service or mental illness will develop sooner or later."

Society Proceedings

Barron—Washburn—Sawyer—Burnett

The members of the Barron–Washburn–Sawyer–Burnett County Medical Society met at the Cumberland Hotel, Cumberland, on May 5. There were eleven physicians present. Dr. Henry A. Sincock, pediatrician from Superior, spoke on "Abdominal Conditions Found in Children, Besides Appendicitis."

Chippewa—Eau Claire—Dunn—Pepin

Two guest speakers appeared on the program of the joint meeting of the Chippewa County Medical Society and the Eau Claire–Dunn–Pepin County Medical Society on May 12 at Hotel Northern at Chippewa Falls. Dr. Harry R. Foerster discussed "Eczematous and Allergic Dermatoses," and Dr. Francis D. Murphy discussed "The Differential Diagnosis and Treatment of Heart Failure and Peripheral Vascular Collapse (Shock Syndrome)." About fifty members were present.

Columbia—Marquette—Adams—Dodge

The medical societies of Columbus–Marquette–Adams and Dodge Counties and the dental societies of Columbia and Dodge Counties held a joint meeting at Hotel Rogers, Beaver Dam, on April 30, preceded by a steak dinner. The two guest speakers were Henry Scott, Ph. D., director of biologic research of the Wisconsin Alumni Research Foundation, Madison, and Dr. M. N. Federspiel, associate clinical professor of surgery at Marquette University School of Medicine, Milwaukee.

Dane

A special meeting of the Dane County Medical Society was held on April 23 for discussion of the Procurement and Assignment Service. Mr. Charles H. Crownhart, secretary of the State Medical Society of Wisconsin, explained how this service operates at both a national and state level.

Thirty-five members were present at the regular monthly meeting of the Dane County Society on May 12 at the Madison Club. A dinner meeting of the Board of Directors preceded the scientific program, which included the following speakers:

"The Community Union in Our War Effort," Mr. Frank Ross, Madison.

"Plastic Surgery," James E. Dollard, M. D., Madison.

"Parenteral Use of Amino Acids in Preoperative, Postoperative and Nephritic States," Anthony R. Curreri, M. D., Madison.

Fond du Lac

Dr. John M. Waugh, Mayo Clinic surgeon, discussed "Vaginal Hysterectomy" at the April 23 meeting of the Fond du Lac County Medical Society at Hotel Retlaw, Fond du Lac. Forty-eight members were present.

Milwaukee

The monthly meeting of the Medical Society of Milwaukee County was held at the Milwaukee Athletic Club on the evening of May 8. On the scientific program, Dr. Walter P. Blount, Milwaukee orthopedist, discussed "The Kenney Treatment of Poliomyelitis," and Dr. Philip S. Hench, guest speaker from The Mayo Clinic, Rochester, discussed "The Management of Rheumatoid Arthritis."

Monroe

The Monroe County Medical Society held its annual meeting at the Sidney Hotel, Sparta, on April 22. After a 6:30 dinner, business was transacted. Dr. DeWitt C. Beebe, Sparta, was reelected president, and Dr. Thomas J. Sheehy, Tomah, was reelected secretary. Dr. Charles S. Phalen, Sparta, was named delegate to the State Medical Society, and Dr. Spencer D. Beebe, Sparta, alternate delegate.

The society was host to Mr. Charles H. Crownhart, secretary of the State Society; Mr. George B. Larson, assistant secretary, and Dr. Henry A. Jegi, Galesville, councilor of the seventh district. Mr. Crownhart discussed "Problems of the Profession in the National Emergency," and Mr. Larson discussed "Medical Care Under Proposals of the Farm Security Administration."

Outagamie

Dr. David M. Gallaher, secretary of the Outagamie County Medical Society, reports that their May meeting was held at the Conway Hotel, Appleton, on the fourteenth. Forty members were present to hear Dr. Eugene F. Carey, Chicago obstetrician and gynecologist, discuss "The Causes and Treatment of Prolonged Labor."

Pierce—St. Croix

A. E. McMAHON, M. D.

When the Pierce–St. Croix County Medical Society met on April 23 at Baldwin, Dr. A. E. McMahon submitted his resignation as secretary, after having served in this capacity since 1929. He came to Wisconsin in 1926 from Iowa, and from 1926 to July 1, 1941, practiced in Glenwood City. At that time he became associated with the Menomonie Clinic. Besides his long service to his local medical society, Dr. McMahon has also held, since election in 1929, the position of delegate to the State Medical Society.

In appreciation the Pierce–St. Croix County Medical Society adopted the following resolution:

"WHEREAS, Circumstances having placed him in a position in which he finds it no longer possible for him to serve as secretary of the Pierce–St. Croix County Medical Society, Dr. A. E. McMahon has placed his resignation before this society, and

"WHEREAS, Dr. McMahon has served this society as secretary for the last twelve years, and during that period has given unstintingly of his time and efforts, often far beyond that which could be expected of a secretary, therefore,

"*Be it resolved*, That Dr. McMahon's resignation as secretary be accepted with regret and with heartfelt thanks and appreciation for his many years of service to us as a society and as individuals,

"*Be it further resolved*, That this resolution be spread upon the minutes of this society and that a copy thereof be presented to Dr. McMahon."

Dr. Chalmer Davee, River Falls, was elected to fill the vacancy caused by the resignation of Dr. McMahon. The guest speaker on the scientific program was Dr. Karl C. Wold, St. Paul, who spoke on "Treatment of Ear, Nose, and Throat Conditions in General Practice."

Racine

Dr. John E. Gonce, head of the Department of Pediatrics, University of Wisconsin Medical School, discussed "Some Aspects of Urinary Infections in Infants and Children" at the May 21 meeting of the Racine County Medical Society. The meeting was preceded by a dinner at the Meadowbrook Country Club, Racine.

Rock

The members of the Rock County Medical Society were entertained at a dinner on April 28 by Miss Iva L. Hartman, superintendent, and the trustees of Pinehurst Sanatorium, Janesville. Forty members were present at the dinner and to hear Dr. William H. Oatway, Jr., assistant professor of medicine at the University of Wisconsin Medical School, discuss "Fungous Diseases of the Lungs."

Sheboygan

The subject under discussion at the May 12 meeting in Sheboygan of the Sheboygan County Medical Society was "The War and the Medical Profession." The speakers were Mr. Charles H. Crownhart, secretary of the State Medical Society; Lieutenant Colonel Amory A. Miller and Captain Norman L. Sheehe, members of the Medical Department Officer Recruiting Board for the State of Wisconsin. About forty members were present.

Winnebago

The Winnebago County Medical Society and the Winnebago County Dental Society held a joint meeting on May 7 at the Athearn Hotel, Oshkosh. About fifty members were present. The speaker was Kenneth W. Penhale, M. D., D. D. S., Chicago, and his subject was "Traumatic Injuries to the Face."

Sixth District

Physicians from Brown, Kewaunee, Door, Fond du Lac, Outagamie, and Winnebago Counties assembled at the Beaumont Hotel, Green Bay, on May 21, for the meeting of the Sixth District Medical Society. The afternoon session included four clinical addresses, each talk being followed by a discussion. The speakers and their subjects were as follows:

"Nonspecific Infection of the Urinary Tract," John B. Wear, M. D., associate professor of urology, University of Wisconsin Medical School, Madison.

"Chronic Disease of the Abdomen," Frederick W. Madison, M. D., associate professor of medicine, Marquette University School of Medicine, Milwaukee.

"Biliary Surgery," Alexander Brunschwig, M. D., associate professor of surgery and roentgenology, University of Chicago School of Medicine, Chicago.

"Compound Fracture Treatment," Carlo S. Scuderi, M. D., Chicago.

In the evening Ludwig Freund, Ph. D., professor of political science at Ripon College, Ripon, spoke on "America's Stake in War and in Peace."

Ninth District

At the annual meeting on May 7 in Stevens Point, Dr. Joseph F. Smith, Wausau, was reelected secretary of the Ninth Councilor District Medical Society, which includes Clark, Green Lake, Waushara, Lincoln, Marathon, Portage, Waupaca, and Wood Counties. Dr. Wallace L. Nelson, Wisconsin Rapids, was elected president to succeed Dr. Edward P.

Crosby, Stevens Point. This election preceded a dinner meeting, during which the following program was presented:

"Surgery of the Colon," Maurice G. Rice, M. D., Stevens Point.

"Postpartum Hemorrhage—Causes, Prevention, and Treatment," John W. Harris, M. D. professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison.

"Differential Diagnosis and Treatment of Organic Heart Disease and Functional Disorders of the Heart," Francis D. Murphy, M. D., clinical professor of medicine, Marquette University School of Medicine, Milwaukee.

Central Wisconsin Society of Ophthalmology and Otolaryngology

The spring meeting of the Central Wisconsin Society of Ophthalmology and Otolaryngology was held at the Gateway Hotel, Land O'Lakes, on May 16 and 17. It was attended by about thirty-five physicians specializing in these fields. The scientific program follows:

May 16

"New Simplified Approaches to Problem of Acute Frontal Sinusitis (illustrated)," Lawrence L. Boies, M. D., professor of otolaryngology, University of Minnesota Medical School, Minneapolis

"Newer Techniques of Surgery of the Extra-Ocular Muscles (illustrated)," Hendrie M. Grant, M. D., associate professor of ophthalmology, University of Minnesota Medical School, Minneapolis

May 17

"Injury to the Jugular Bulb (case report)," George H. Boyce, M. D., Iron Mountain, Michigan

"The Diagnosis and Treatment of Heterophoria, a New Version," Hendrie M. Grant, M. D.

"Headache From the View Point of the Otolaryngologist," Lawrence L. Boies, M. D.

Motion pictures

"Technique of Direct Laryngoscopy and Diagnosis," Paul Holinger, M. D., University of Illinois Medical School, Chicago

"Treatment of Traumatic Injuries to the Face," Gordon B. New, M. D., professor of otology and rhinology, University of Minnesota Graduate School, Rochester, and John B. Erich, M. D., Rochester

"Diagnosis and Treatment of the Acute Mastoid and Petrositis," Samuel J. Kopetzky, professor of otology, New York Polyclinic Medical School and Hospital, New York City

Technique of Various Eye Operations as Performed by Wendell L. Hughes, M. D., in the New York Eye and Ear Infirmary

Orthoptic Treatment of Squint as Carried Out in the New York Eye and Ear Infirmary

Milwaukee Neuro-Psychiatric Society

The members of the Milwaukee Neuro-Psychiatric Society were guests of Normandale Sanitarium at the Memorial Union, Madison, on April 22. On the scientific program, which was presented at Service Memorial Institutes, the guest speaker was Dr. William G. Lennox, assistant professor of neurology at Harvard Medical School. His subject was "Twins, Brain Waves and Epilepsy."

Milwaukee Oto-Ophthalmic Society

At the meeting of the Milwaukee Oto-Ophthalmic Society at the University Club on May 12, the following officers were elected:

President, Dr. Edward R. Ryan, Milwaukee

Vice-president, Dr. Mark J. Bach, Milwaukee

Secretary-treasurer, Dr. Ralph T. Rank, Milwaukee

Directors, Dr. Henry B. Beeson, Racine; Dr. Jasper M. Molsberry, Milwaukee, and Dr. John W. Truitt, Milwaukee

Milwaukee Society of Clinical Surgery

At a meeting in the Heidelberg Club, Sheboygan, on May 13, the Milwaukee Society of Clinical Surgery presented the following program:

"The Use of the Polarograph for Laboratory Diagnosis," Friedrich Eigenberger, M. D., Sheboygan.

"Preoperative and Postoperative Medical Care of Surgical Patients," Paul B. Mason, M. D., Sheboygan.

The golfers were guests in the afternoon of Dr. Jerry W. McRoberts, Sheboygan, at Pine Hills Country Club.

Wisconsin Trudeau Society and Michigan Trudeau Society

A combined meeting of the Wisconsin Trudeau Society and the Michigan Trudeau Society was held at the Four Seasons' Club, Miscauno Islands, Pembine, on June 12 and 13. The program follows:

Friday Afternoon, June 12

Everett W. Gaikema, M. D., Grand Rapids, presiding

I. Sputum Examination Methods, Henry E. Cope, M. D., Lansing, and Christopher J. Stringer, M. D., Lansing

II. Symposium on Value and Significance of Positive Gastric Lavages in the Diagnosis and Treatment of Pulmonary Tuberculosis

A. Comparison of Direct Smears and Guinea Pig Inoculations, Einar R. Daniels, M. D., Wauwatosa
B. Evaluation of Significance During Treatment, Joseph J. Furling, M. D., Milwaukee
C. Prognostic Significance in the Treated Patient, George C. Owen, M. D., Oshkosh

III. Preliminary Report on a Large Series of Routine Admission Bronchoscopies, Anthony V. Cadden, M. D., Wauwatosa, and David Salkin, M. D., Hopemount, West Virginia

IV. Treatment with Minimum Hospitalization, Charles R. Smith, M. D., Houghton

Saturday Morning, June 13

George C. Owen, M. D., Oshkosh, presiding

I. Mechanical Aids in Collapse Therapy, William H. Oatway, Jr., M. D., Madison

II. Perirectal Abscess and Fistulae, John Sanders, M. D., Waiakoa, Maui, Hawaii, and John B. Barnwell, M. D., Ann Arbor

III. The Present Status of Extrapleural Pneumothorax, William M. Tuttle, M. D., Detroit

IV. Experience with the Monaldi Method of Cavity Drainage, John D. Steele, M. D., Milwaukee

News Items and Personals

LLOYD H. ZIEGLER, M. D.

The appointment of *Dr. Lloyd H. Ziegler* as medical director of the Milwaukee Sanitarium, Wauwatosa, to succeed the late *Dr. Rock Sleyster*, was recently announced.

Dr. Ziegler, who received his M. D. degree from the University of Minnesota Medical School, had graduate training in psychiatry and neurology at St. Elizabeth's Hospital, Washington, D. C.; Henry Phipps Clinic, Johns Hopkins Hospital, Baltimore, and the Mayo Clinic, Rochester, Minnesota. From 1926 to 1930 he was staff consultant in neurology and psychiatry at the Mayo Clinic, and in 1930 he became professor of neurology and psychiatry at the Albany Medical College and neurologist and psychiatrist-in-chief for the Albany Hospital, Albany, New York. On November 1, 1937, he became associate director of the Milwaukee Sanitarium, Wauwatosa, and lecturer in psychiatry at the University of Illinois College of Medicine, Chicago.

Dr. Ziegler holds membership in numerous local, state, and national medical societies, among them the American Medical Association, American Psychiatric Association, American Neurological Society, American Association for the Advancement of Science, and Association for Research in Nervous and Mental Diseases. He is a member of, and helped to organize, the American Board of Psychiatry and Neurology.

In 1931 *Dr. Ziegler* attended the First International Neurological Congress in Berne, Switzerland, and in 1935, the Second Congress which convened in London, and on these and other occasions he has visited numerous medical centers of Europe.

When *Dr. F. E. Butler*, Menomonie, president-elect of the State Medical Society, spoke to fellow Rotarians on May 14 he outlined the wartime role of the medical profession, describing the work of Procurement and Assignment Service in allocating physicians to positions in the armed forces without depriving certain civilian areas of medical care.

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Six members of the State Medical Society participated in the thirteenth annual Tri-State Hospital Assembly in Chicago on May 6, 7 and 8, as follows:

"Physiotherapy in Arthritis," *Vernon C. Turner, M. D.*, Milwaukee.

"Non-Orthopedic Conditions Treated by Physical Therapy," *Herbert W. Pohle, M. D.*, Milwaukee.

Panel Discussion: "Application of Fundamental Principles of Good Hospital Administration and Service in Special Departments Serving the Patient,—the Surgeon," *Russell M. Kurten, M. D.*, Racine; "The Obstetrician," *Ralph E. Campbell, M. D.*, Madison.

"Water Balance," *Arthur A. Schaefer, M. D.*, Milwaukee.

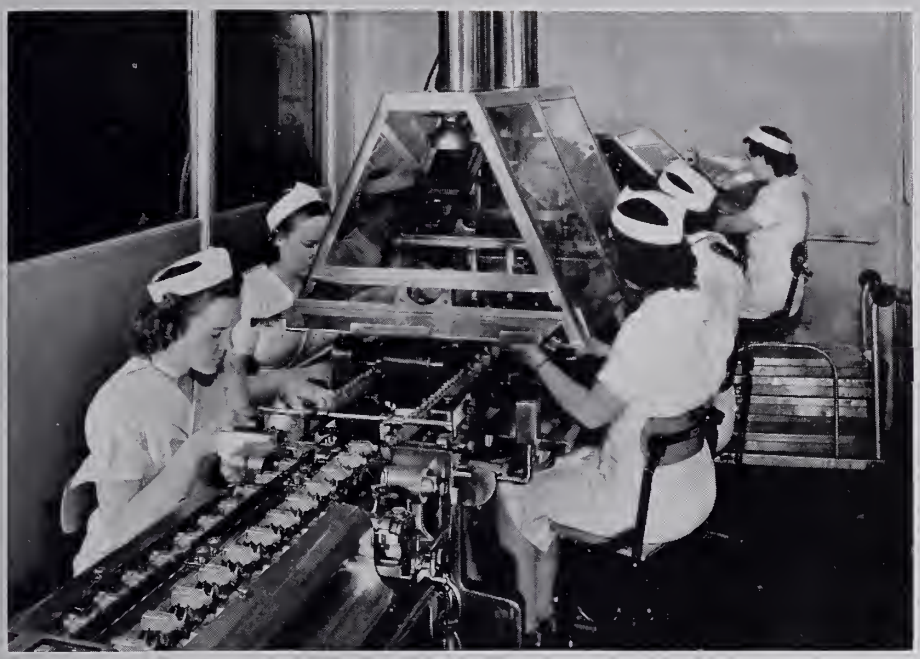
"Information Please," *Harold M. Coon, M. D.*, Madison.

—△—

Dr. Erwin C. Cary, Reedsville, has been reappointed health officer for the village of Reedsville and for the townships of Rockland and Franklin.

—△—

A quarter century of service to Marathon and surrounding counties was celebrated on Hospital Day, when Mount View Sanatorium, Wausau, held its twenty-fifth anniversary program. The principal speaker on the program was *Dr. Timothy L. Harrington*, Milwaukee, a member of the senior council of the Wisconsin Anti-Tuberculosis Association, who discussed "The Sanatorium Movement in the United States and Wisconsin."



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Major Albert N. Tousignant, Oconto physician and surgeon, who was chief of the medical staff at Sternberg General Hospital in Manila, Philippine Islands, when the war broke out in the Pacific theater, and was then transferred to Fort Stotsenburg, was reported "missing in action" on May 22. *Dr. Tousignant*, a reserve officer, was called into active army service in the Medical Corps on April 15, 1941.

—△—

Dr. John Hogan, Kaukauna, has been selected as city health officer to succeed *Dr. Charles D. Boyd*, who asked to be released from that office which he has held for fourteen years. The city council adopted a resolution to send *Dr. Boyd* a letter of praise for his excellent work.

—△—

Dedication of a blue spruce tree on hospital hill to *Dr. Margaret Caldwell* of Waukesha was one of the features of the twenty-first annual celebration of Hospital Day by the Waukesha Memorial Hospital. The tree was transplanted to the hill from the grounds of the former home of the late dean of women physicians in Wisconsin. *Dr. Caldwell*, who was an honorary member of the State Medical Society of Wisconsin, died in 1938 at the age of ninety-two.

—△—

Dr. Robert E. Fitzgerald, Milwaukee, was recently named chief of staff at St. Joseph's Hospital, Milwaukee. He succeeds *Dr. Francis D. Murphy*, who last October was named to fill an endowed chair of medicine at Marquette University School of Medicine. *Dr. James R. Regan*, Milwaukee, was named secretary-treasurer of the hospital staff.

—△—

Dr. Patrick G. McCabe, Fond du Lac, was elected county physician to succeed the late *Dr. Joseph W. Helz*, Fond du Lac, at the monthly meeting of the county board on May 11.

—△—

An enlightening talk on first aid instruction to two classes in Durand was given at the Kiwanis meeting on May 18 by *Dr. Raymond R. Richards*. He stressed the importance of knowing how to give first aid.

—△—

Dr. Frank O. Brunckhorst, Neenah, was reelected city health officer by the board of health on May 12. *Dr. Brunckhorst*, who was named for a two-year term, began his fourth term as city health officer.

—△—

Valuable information about the control of cancer was given by *Dr. Elverse M. Jordan*, Green Bay, when he spoke at the meeting of the Daughters of Isabella on May 28 in Green Bay.

—△—

"Obstetric Problems Encountered by the General Practitioner" was the topic discussed at the meeting of the Physicians' Club of West Allis on May 7 at the home of *Dr. Martin C. Malensek*. The discussion was led by *Dr. Frank E. Darling, Jr.*, Milwaukee.

The State Medical Society's film strip entitled "Health Achievements in Wisconsin" was viewed on May 11 by the members of the Rotary Club of Janesville. The commentary was given by Mr. George B. Larson, assistant secretary of the Society.

—△—

The reappointment of *Dr. Henry S. Atkinson* as city physician in Green Bay was recently announced. He has served in this capacity for a number of years and was also health officer until the duties were divided.

—△—

Among the speakers at the meeting of the Council of Social Agencies in Sheboygan on May 5 was *Dr. Gustav J. Hildebrand*, health commissioner of the city. He gave an encouraging report concerning the high percentage of children immunized against smallpox and diphtheria.

—△—

Two educational films on tuberculosis were shown the first part of May to several thousand Green Bay high school students by *Dr. George M. Shinners*, health commissioner. The movies, entitled "Let My People Live," depicting the ravages of tuberculosis among Negroes, and "Behind in the Shadows," showing the use of x-rays in detecting the disease in a high school boy, are interesting and highly educational, the health commissioner reports.

—△—

On May 1 *Dr. Herman M. Lynch* assumed the position of health officer of West Bend. The vacancy occurred upon resignation of *Dr. Willibald J. Wehle* after thirty-five years of service.

—△—

Dr. Sarkis H. Kash was appointed health commissioner of Cudahy at the meeting of the board of health on April 27. His term expires May 1, 1944.

—△—

Dr. Eugenia Cameron of the staff of the Wisconsin State Board of Health spoke on April 27 at the meeting of the Parent–Teacher Association in West Bend. Her subject was "Mental Health as a Phase of Child Welfare."

—△—

Four River Falls physicians, *Dr. Charles A. Dawson, Chalmer Davee, Charles E. McJilton*, and *Rolla U. Cairns*, have formed and incorporated under the laws of Wisconsin, the River Falls Clinic.

—△—

On the occasion of the recent second annual Central High School occupational guidance conference in Madison, representatives of twenty varied occupational fields addressed the pupils on opportunities and training needs. One of the speakers was *Dr. W. D. Stovall*, professor of hygiene at the University of Wisconsin Medical School and director of Service Memorial Institutes.

—△—

At the annual meeting of staff members of St. Alphonsus Hospital, Port Washington, *Dr. Ted D. Elbe*, Thiensville, was elected president, and *Dr. Oscar W. Hurth*, Cedarburg, secretary.

IRON LUNGS

The National Foundation for Infantile Paralysis has compiled from records available on April 1, 1942, a list of adult cabinet type respirators or "iron lungs." This list contains only those respirators which have been approved by the Council on Physical Therapy of the American Medical Association. These standard cabinet type respirators are not to be confused with other machines such as chest type respirators, resuscitators, inhalators or aspirators.

The following is a list of respirators in Wisconsin:

Delavan *(Walworth)*—Walworth County

Green Bay *(Brown)*—Chicago & North Western Ry. Co.

Juneau *(Dodge)*—J. C. C. Auxiliary

Kaukauna *(Outagamie)*—St. Elizabeth Hospital

Kenosha (Kenosha)—Kenosha Hospital

La Crosse *(La Crosse)*—St. Francis Hospital

Madison *(Dane)*—State of Wisconsin General Hospital, (2)

Manitowoc *(Manitowoc)*—Holy Family Hospital, (3)

Milwaukee *(Milwaukee)*—City Health Department, Johnston Emergency Hospital, Milwaukee County Hospital, (3) (2 owned by Milwaukee County Chapter of The National Foundation)

Neenah *(Winnebago)* — Theda Clark Memorial Hospital

Oshkosh *(Winnebago)*—Mercy Hospital, Winnebago County Court House

Port Washington *(Ozaukee)* — St. Alphonsus Hospital

Racine *(Racine)*—St. Luke's Hospital

Sheboygan *(Sheboygan)* — Sheboygan Memorial Hospital

Watertown *(Jefferson)*—St. Mary's Hospital

West Bend *(Washington)*—St. Joseph's Hospital

Wild Rose *(Waushara)*—Waushara County American Legion

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Symposiums on Heart, Hemorrhage, Sulfonamides, and the Physician and the War

One Hundred First Anniversary Meeting, September 14, 15, and 16

THE Council on Scientific Work, through Dr. Erwin R. Schmidt, has arranged a carefully integrated scientific program for the One Hundred First Anniversary Meeting to be held in the Milwaukee Auditorium on September 14, 15, and 16. Symposiums have been arranged for four of the five general sessions, Wednesday morning being surrendered to the specialties.

Those cooperating with Dr. Schmidt in the preparation of the programs for the sectional meetings are: *Obstetrics and Gynecology*—Dr. Francis M. Frechette, Janesville; *Surgery*—Dr. Albert R. Tormey, Madison; *Medicine*—Dr. Gjermund Hoyme, Eau Claire; *Ophthalmology and Otolaryngology*—Dr. Reinhold O. Ebert, Oshkosh; *Pediatrics*—Dr. Francis R. Janney, Milwaukee; *Urology*—Dr. Alf H. Gundersen, La Crosse; *Cardiology*—Dr. Chester M. Kurtz, Milwaukee, and *Orthopedics*—Drs. Chester C. Schneider and Walter P. Blount, both of Milwaukee.

Guest speakers who have accepted program assignments are:

Arlie R. Barnes, professor of medicine, University of Minnesota Graduate School, Minneapolis–Rochester; The Mayo Clinic, Rochester, Minnesota

Wesley M. Spink, associate professor of medicine, University of Minnesota Medical School, Minneapolis

Clayton G. Loosli, Frank Billings Medical Clinics, Chicago

Edward H. Rynearson, assistant professor of medicine, University of Minnesota Graduate School, Minneapolis–Rochester; The Mayo Clinic, Rochester, Minnesota

Tom D. Spies, associate professor of medicine, University of Cincinnati College of Medicine, Cincinnati

Herman O. McPheeters, Minneapolis

Hilger P. Jenkins, associate professor of surgery, University of Chicago, The School of Medicine, Chicago

Julius Jensen, assistant professor of clinical medicine, Washington University School of Medicine, St. Louis

Bert I. Beverly, assistant clinical professor of pediatrics, Rush Medical College, University of Chicago, Chicago

Maurice L. Blatt, professor of pediatrics, Illinois College of Medicine, Chicago

Howard P. Doub, Henry Ford Hospital, Detroit

Wallace H. Cole, professor of orthopedic surgery and surgery, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis

Winfield W. Scott, Chicago

Thomas L. Pool, Rochester, Minnesota

Lt. Col. William C. Porter, Walter Reed General Hospital, Washington, D. C.

Dr. Schmidt has arranged the following schedule for the symposiums: Monday morning—*Heart;* Monday afternoon—*Hemorrhage;* Tuesday morning — *Sulfonamides;* Tuesday afternoon—subjects in various fields with topics such as *Pneumonia and Chemotherapy, Diverticulitis of the Gastro-Intestinal Tract, The Actual Clinical Disturbances of the Endocrine Glands,* and *Advances in Vitamin Therapy,* and Wednesday afternoon—*The Physician and the War.*

Topics to be presented at the various symposiums are:

Heart

Physiology of the Heart and Circulation
Physiologic Principles in Cardiac Diagnosis

Diagnosis in Cardiac Disease

Treatment of Cardiac Emergencies in the Home

Cardiac Treatment in the Hospital

Surgery of Cardiac Disease

Hemorrhage

Pathologic Physiology of Hemorrhage

Clinical Failure of Circulation—Hemorrhage and Shock

Treatment—Clinical Failure of Circulation—Shock

Treatment of Traumatic Hemorrhage

Treatment of Obstetrical Hemorrhage

Management of Nontraumatic Hemorrhage

Sulfonamides

Pharmacology of Sulfonamides

Sulfonamides in General Practice

Sulfonamides in Surgery

Clinical Applications and Complications of Sulfonamides

Round-Table Luncheons

To meet an emphatic demand, the Council on Scientific Work has arranged to increase still further the number of round-table luncheons. Approximately sixty round tables will be conducted during the three days of the meeting. Attendance, as in the past, will be by registration only and will be limited to twenty members.

Among the subjects scheduled for discussion are the following:

Management of Occiput Posteriors
Hormones and Sex
Surgery of the Colon
Early Lesions of the Breast
Infant Feeding
Everyday Facts About Vitamins
Fractures of the Arm
The Physician and the War (to be held every day of the meeting)
New Drugs
Cardiac Emergencies in the Home
Bedside Medicine and Newer Drugs
What To Do About Prolonged Labor

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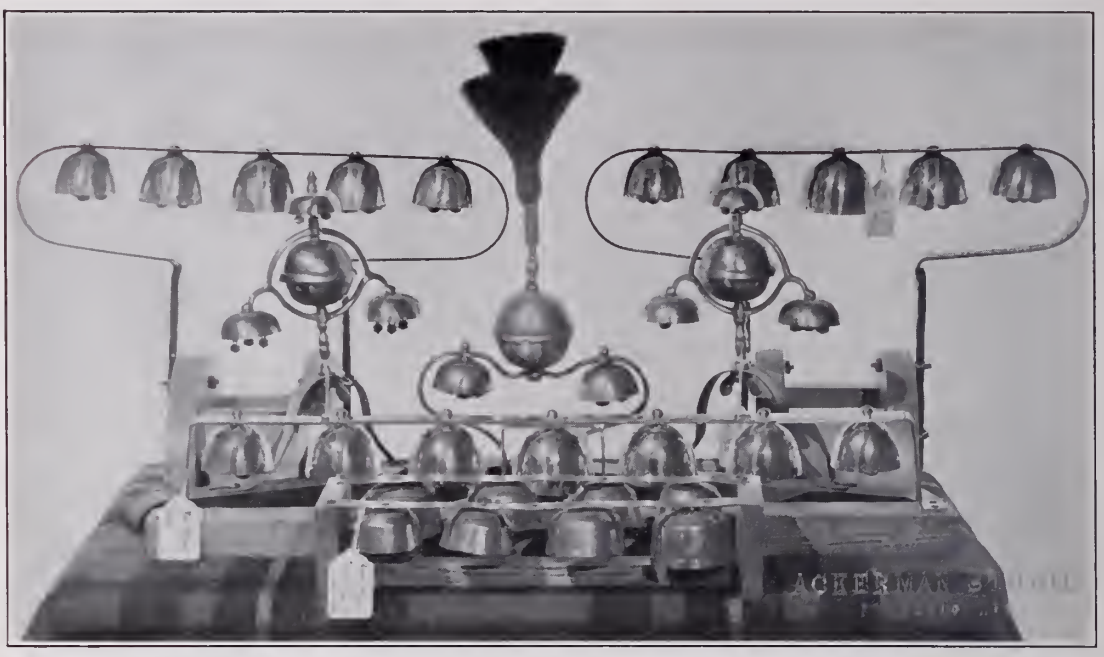

Part of a collection of bells to be exhibited by Dr. R. G. Arveson (past-president and councilor, tenth district) in the Hobby Show at the One Hundred First Anniversary Meeting. Shaft bells in foreground were presented to Dr. F. G. Johnson, Sr., Iron River (councilor, eleventh district), by Mrs. Johnson on Christmas, 1893.

Motion Pictures

Carefully selected and outstanding motion pictures will be shown during the first hour every morning and the last hour every afternoon. As previously announced, the Council on Scientific Work assigned the development of this portion of the program to Dr. H. Kent Tenney, Madison. The motion pictures, many of which will be in sound and color, are:

MONDAY, SEPTEMBER 14

Morning

Diagnosis of Early Syphilis
Diagnosis of Late Syphilis
Management of Syphilis

Afternoon

Otoscopy in the Inflammations

TUESDAY, SEPTEMBER 15

Morning

Appendicitis in Children

Afternoon

Treatment of Breech Presentation

WEDNESDAY, SEPTEMBER 16

Morning

Skin Graft
Prostoscopic Cinematography

Scientific Exhibits

Visual methods of instruction are of unquestioned value both in undergraduate and postgraduate medical education, as is evident by the enthusiasm with which scientific exhibits have been accepted at previous meetings of the Society. This was especially true of the applied anatomy exhibits at the Centennial Meeting by the University of Wisconsin Medical School and Marquette University School of Medicine, as well as others such as the orthodiascopic exhibit by Dr. John E. Habbe of Milwaukee, and the manikin demonstrations by the Wisconsin Society of Obstetrics and Gynecology.

Recognizing the effectiveness of this medium of medical education, the Council on Scientific Work increased the space allotted to exhibits. Of particular interest this year will be a special section devoted to *The Medical Profession and the War.* Here will be presented exhibits of current interest relating to active military service and the protection of the civilian population. Dr. C. J. Smiles, the member of the Council on Scientific Work in charge of this portion of the program, has arranged numerous other ex-

hibits on the newer advances in the treatment of the sick, among which are:

- Fenestration Operation for Improvement in Hearing in Otosclerosis
- Cancer of the Breast
- Bronchoscopy
- Tuberculosis
- Cardiology
- Rheumatism
- Poliomyelitis
- Amputations
- Use and Abuse of Barbiturates
- Burns
- Plastic surgery

Hobby Show

The arrangements for the Hobby Show, also under the direction of Dr. C. J. Smiles, are near completion. Final allocation of exhibit space will be made this month, and hobby enthusiasts intending to demonstrate their collections are urged to advise Dr. Smiles at once.

The Hobby Show will be conducted in the main arena of the Milwaukee Auditorium, where the scientific and technical exhibits will be presented.

One of the members of the Society who has reserved space is Dr. Paul F. Doege, Marshfield, who will have an unusual display of firearms used over a period of several hundred years. Dr. Doege's complete collection includes some 300 firearms.

Among other outstanding exhibits will be paintings by Dr. Maurice A. Hardgrove, Milwaukee; waterfowl pictures by Dr. Howard J. Lee, Oshkosh; bells by Dr. R. G. Arveson, Frederic; motion pictures of flowers by Dr. A. S. Jackson, Madison; kodachrome transparencies by Dr. M. G. Peterman, Milwaukee, and a stamp collection by Dr. J. J. Barrock, Milwaukee.

Reserve Dates

Reserve now the dates of September 14, 15 and 16 for your attendance at the One Hundred First Anniversary Meeting of the Society. For a synopsis of the program, see page 511.

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Reregistration and Inventory of Narcotics and Marihuana

Reregistration by July 1.—The attention of all Wisconsin physicians now using narcotics or marihuana in their professional work is called to the requirement that there must be separate reregistration for each executed and filed with the Collector of Internal Revenue, Milwaukee, Wisconsin, together with an annual tax of $1, on or before July 1. While ordinarily a physician will receive a reregistration form both for narcotics and marihuana prior to June 1, he is not excused for failure to reregister merely because he does not get such a form, since it is his duty to make application for reregistration.

Inventory due by July 1.—In addition to reregistering and paying the annual tax, each Wisconsin physician desirous of administering, dispensing, prescribing, giving or transporting narcotics or marihuana, must file a separate inventory of each with the Collector of Internal Revenue, Milwaukee, Wisconsin, prior to July 1. It is the duty of the physician to obtain forms, even though these may not have been forwarded to him by the Collector of Internal Revenue in Milwaukee.

Discontinuance.—A physician now registered under the narcotic or marihuana acts, who for military or other reasons expects to discontinue his practice or the administration of those drugs in the near future, should, if possible, notify the Collector of Internal Revenue of his intention not later than June 30, the close of the tax year. He will receive special instructions as to disposition of his stock on hand. A physician discontinuing his practice or the administering of narcotics or marihuana between July 1, 1942 and June 30, 1943, may retain his stock of narcotics and marihuana in his office so long as each is carefully kept out of ordinary reach, or he may cancel both licenses and dispose of his stock on hand. The preferable procedure for the physician entering military service during the last year would doubtless be to cancel whichever license he may have because of the uncertainty of his return in time for registration for the year beginning July 1, 1943.

Removal.—The removal of a professional office from one location to another must be reported to the Collector of Internal Revenue, Milwaukee, Wisconsin, and the Collector will thereupon reregister the physician at his new address without the taking out of a new permit or payment of an additional tax.

Two Offices.—A physician who maintains two or more offices in separate locations must register each office separately and pay the annual tax of $1 in each location, both for narcotics and marihuana, in the event he desires to use both for professional purposes.

For more complete details see page 1237 of the December issue of *The Wisconsin Medical Journal.*

Severe penalties, including heavy fines or imprisonment, or both, are imposed for those who fail to comply with the statutory provisions for annual registration, payment of tax and inventory by physicians who dispense narcotics, marihuana, or both.

AMENDMENT TO CONSTITUTION.—In conformity with the provision in the Constitution of the State Medical Society that amendments shall be published twice before the meeting on which they will receive a vote, the following amendment, presented at the request of the Council, is printed:

Resolved, That the Constitution of the State Medical Society of Wisconsin be amended by striking from Article II the eleventh and twelfth lines.

Program Synopsis

One Hundred First Anniversary Meeting

SUNDAY, SEPTEMBER 13

P. M.

6:30 House of Delegates—Banquet Room (Fifth Floor), Schroeder Hotel

MONDAY, SEPTEMBER 14

A. M.

8:00 Registration — Main Arena, Milwaukee Auditorium
9:15 General Session—"The Heart"—Plankinton Hall
10:00 Recess to view exhibits
10:30 General Session—"The Heart"—Plankinton Hall

P. M.

12:10 Round-Table Luncheons—Schroeder Hotel
2:00 General Session—"Hemorrhage" — Plankinton Hall
3:20 Recess to view exhibits
3:40 General Session—"Hemorrhage" — Plankinton Hall
6:30 House of Delegates—Pere Marquette Room (Fifth Floor), Schroeder Hotel
8:30 Smoker—Crystal Ballroom (Fifth Floor), Schroeder Hotel

TUESDAY, SEPTEMBER 15

A. M.

8:00 House of Delegates—Banquet Room (Fifth Floor), Schroeder Hotel
9:20 General Session—"Sulfonamides"—Plankinton Hall
10:20 Recess to view exhibits
10:40 General Session—"Sulfonamides"—Plankinton Hall

P. M.

12:10 Round-Table Luncheons—Schroeder Hotel
2:15 General Session—Plankinton Hall
3:00 Recess to view exhibits
3:50 General Session—Plankinton Hall
6:45 Annual Dinner—Crystal Ballroom—Schroeder Hotel

WEDNESDAY, SEPTEMBER 16

A. M.

8:30 Section on Ophthalmology—Juneau Hall North (First Floor)
9:00 Section on Medicine and Cardiology—Plankinton Hall (Second Floor)
9:00 Obstetrics and Gynecology — Walker Hall (First Floor)
9:00 Radiology—Committee Room D (Second Floor)
9:00 Surgery—Engelmann Hall (Second Floor)
9:00 Pediatrics—South Kilbourn Hall (First Floor)
9:00 Orthopedics
9:00 Urology

P. M.

12:10 Round-Table Luncheons—Schroeder Hotel
2:00 Section on Otolaryngology—Juneau Hall North (First Floor)
2:15 General Session—Plankinton Hall (Second Floor)
3:30 Recess of General Session to view exhibits
3:50 General Session—Plankinton Hall (Second Floor)

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FRACTURES & TRAUMATIC SURGERY—Two Weeks Intensive Course will be offered starting June 29th and September 21st. Informal Course available every week.

GYNECOLOGY—Two Weeks Intensive Course will be offered starting October 5th. One Month Personal Course starting August 3rd. Clinical and Diagnostic Courses every week.

OBSTETRICS—Two Weeks Intensive Course will be offered starting September 21st. Three Weeks Course starting August 10th. Informal Course every week.

OTOLARYNGOLOGY—Two Weeks Intensive Course will be offered starting September 14th. Clinical and Special Courses every week.

OPTHALMOLOGY—Two Weeks Intensive Course will he offered starting September 28th. Five Weeks Course in Refraction Methods starting Octoher 19th. Informal course every week.

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CORRESPONDENCE

The Wisconsin Anti-Tuberculosis Association

May 7, 1942

State Medical Society of Wisconsin
Madison, Wisconsin
Gentlemen:

At the annual meeting of the Wisconsin Anti-Tuberculosis Association on April 17, a resolution of condolences in memory of Mr. J. G. Crownhart and other friends of the Association, who left us during the past year, was presented and adopted. We are taking the liberty of sending you a copy of the resolution herewith.

Very truly yours,
Signed: Oscar Lotz, M. D.
Executive Secretary

Resolution of Condolences
(Excerpt)

Since the members and friends of the Wisconsin Anti-Tuberculosis Association last gathered together in fellowship and counsel, many of our most admired and beloved associates have passed from our midst. We recall them in the strength of their mind and character, the camaraderie of their heart and hand, the high and unswerving goals to which they pledged themselves and the positive achievements into which, by the zeal of their heart and hand, these goals were translated. We think of them as they lived among us, and thinking of them so, pay tribute to them. Because they have walked about on the earth and worked among us, this Wisconsin of ours is a fairer place for those now living and for generations yet unborn.

Dr. Rock Sleyster, Wauwatosa, Wisconsin psychiatrist, only Wisconsin physician ever to be elected to the presidency of the American Medical Association, and a director, at the time of his death, of both the W. A. T. A. and the National Tuberculosis Association.

Dr. Charles H. Stoddard, Milwaukee, a founding father of the W. A. T. A. and counsellor and friend, former president and at the time of his death its recording secretary.

Dr. Gilbert E. Seaman, Madison, senior councillor of the W. A. T. A., another long-time director and elder statesman, who also in his rich and busy lifetime distinguished himself as chief surgeon of the Sixth Army Corps and as head of Wisconsin's Division of Mental Hygiene.

Dr. Reuben H. Stiehm, Madison, former staff physician of the W. A. T. A., who in a short and brilliant life developed at the University of Wisconsin what has been called the finest student tuberculosis detection program at any large American university.

Mr. J. G. Crownhart, Madison, executive secretary of the State Medical Society, cut off prematurely in the fullness of needed and useful life.

Be it resolved, That the members and friends of the Wisconsin Anti-Tuberculosis Association record in these words of remembrance their sense of honor and affection for these men and women, of appreciation for having been privileged to know and work with them, and of gratefulness for what their lives have meant to Wisconsin. To the members of their families we extend the hand of silent sympathy.

SOCIETY RECORDS

New Members

J. A. Megna, 1859 North Cambridge Street, Milwaukee.

Louis Babby, 2430 West Wisconsin Avenue, Milwaukee.

R. C. Morris, Fort Atkinson.

M. J. Ruzicka, Boscobel.

V. W. Nordholm, Ellsworth.

Changes in Address

James Christiansen, Washta, Ia., to 124 Fountain Avenue, Waukesha.

L. H. Donath, Lake Geneva, to 231 West Michigan Street, Milwaukee.

H. P. Weiland, Madison, to Verona.

N. M. Wilson, Hines, Ill., to Grimms.

A. J. Hertzog, Eau Claire, to St. Barnabas Hospital, 920 South Seventh Street, Minneapolis, Minn.

C. F. Sherman, Fayetteville, N. C., to Veterans Hospital, Minneapolis, Minn.

J. W. Doughty, Delavan, to 326 El Paseo Avenue, Millbrae, Calif.

Adolf Wallner, Watertown, to 410 Apple Tree Road, Fox Point, Milwaukee.

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E. V. Brumbaugh, Beaver Dam, to 854 South Seventy-sixth Street, West Allis.

W. G. Winter, Milwaukee, to Santa Barbara County Health Department, Santa Barbara, Calif.

B. K. Ozanne, Neenah, to 1430 Mound Street, Madison.

Mary Allen, Green Bay, to Broadford Street, Dover, Del.

J. M. Regan, Milwaukee, to Keshena.

BIRTHS

A daughter, Ruth Mary, to Dr. and Mrs. George O. Shaner, Milwaukee, on May 13.

A son to Dr. and Mrs. Andre H. Lamal, Ashland, on April 8.

A son to Dr. and Mrs. Charles J. Newcomb, Milwaukee, on May 2.

A daughter to Dr. and Mrs. Alvin G. Seelman, Milwaukee, on April 18.

A son, Kenneth, to Dr. and Mrs. Kenneth C. Kehl, Racine, on April 24.

DEATHS

Dr. Kenneth W. Davis died at the home of his parents in Green Bay on April 24 following a brief illness. He suffered critical injuries in an automobile accident a few years ago and since then had found practicing his profession difficult.

Dr. Davis was born in 1908 and was graduated from the University of Wisconsin Medical School in 1933. He practiced in Neillsville and DePere, Wisconsin, and in Dwight, Illinois.

Dr. Davis was formerly a member of the Winnebago County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow, one son, Richard, and his parents, Mr. and Mrs. William H. Davis, Green Bay.

Dr. Charles A. DeVoe, Berlin, died suddenly from heart trouble on May 1. He was born in Lambetien in 1872, and received his M. D. degree from the University of Illinois College of Medicine in 1900. He practiced in Rosendale from 1900 to 1910, at which time he came to Berlin and continued his practice up until a year ago when, because of poor health, he retired from active work.

He was formerly a member of the Green Lake–Waushara–Adams County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow; a brother, H. M. DeVoe of Oakfield; a daughter, Mrs. Dorothy Korn, Rochester, New York, and a son, Allen W., East Lansing, Michigan.

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DEATHS—Continued

Dr. Joseph W. Helz, Fond du Lac, a practicing physician for nearly forty years, was stricken by a heart attack on May 5.

A native of Mount Calvary, Dr. Helz was born in 1879. He received his elementary education in the parochial school at Mount Calvary, and later was graduated from St. Lawrence College of that place. Entering the University of Illinois College of Medicine, he received his M. D. degree in 1903.

Dr. Helz began the practice of medicine in Fond du Lac in 1904. For a time he was city physician, and at the time of his death he was county physician. He was a member of the Fond du Lac County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow, and two daughters, Mrs. John J. Hilt of Waukegan, Illinois, and Mrs. Louie Andrew of Fond du Lac.

Dr. Bernard W. Mast, La Crosse, died on April 29, after suffering a heart attack while on duty at the Grandview Clinic the day before.

Outstanding as a physician and surgeon, Dr. Mast specialized in obstetrics, and was made chief of staff at Grandview Hospital in 1940. Born in Tomah in 1885, he received his early education there and then went to the University of Iowa. Later he transferred to the Chicago College of Medicine and Surgery, from which he received his M. D. degree in 1910. He served his internship at Holy Family Hospital, Manitowoc. Following this he practiced for a time in North Dakota and in Sparta, joining the staff of Grandview Hospital in 1913.

Dr. Mast was active in medical circles, holding membership in the La Crosse County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow; a daughter, Mary Alice; his parents, Mr. and Mrs. John Mast, Tomah; two brothers, John, Glen Ellyn, Illinois, and Vincent, Freeport, Illinois; and one sister, Mrs. Edward Artz, Clifton.

Dr. Louis Richardson, Jump River, died on April 19. He was eighty years of age, and had lived in Jump River since 1932, after retiring from his medical practice in Nebraska. He was graduated from the University of Nebraska College of Medicine in 1890, and followed his profession in Nebraska for forty years.

Surviving him are four children, Mrs. L. Coates of Fremont, Nebraska, Mrs. Soren Meilgaard and Miss Eunice, both of Jump River, and William of Waterloo, Nebraska.

Dr. J. Newton Sisk, Madison roentgenologist and radiologist of the Jackson Clinic and Methodist Hospital, died on April 25 of a cerebral hemorrhage. He had been active until the time of his death.

Dr. Sisk was born in Weatherford, Texas, and was graduated from Baylor University College of Medicine, Dallas, in 1921. He assumed the position of roentgenologist at the Jackson Clinic in 1923, and was recognized for his unusual diagnostic ability and exceptional skill in this field. He contributed numerous papers to the medical literature both in state and national journals.

Dr. Sisk was a member of the Dane County Medical Society, State Medical Society of Wisconsin, American Medical Association, Radiological Society of North America, and American College of Radiology, and a diplomate of the American Board of Radiology.

He took an active part in medical society affairs, both local and national, and because of his knowledge of medical economics was selected in 1937 by the State Medical Society as one of five representative physicians to comprise the Committee to Study the Distribution of Health Service and Sickness Care in Wisconsin. He was vice-speaker of the House of Delegates of the State Medical Society in 1937, and in 1938 was elected speaker and served in the 1939 and 1940 sessions. In the 1941 session the House of Delegates paid high tribute to Dr. Sisk for his exceptional and faithful service, in presenting him with a gavel, symbolic of the office of speaker.

Surviving him are his widow, two children, Donald and Joan, his mother, a brother, and two sisters.

Dr. Hubert S. Steenberg, Milwaukee, a veteran of the Spanish–American War and World War I, died on April 26 at the Veterans Administration Hospital. Born in Fond du Lac in 1876, he was graduated from Milwaukee Medical College in 1902. He practiced in Milwaukee during the period between the Spanish–American and World Wars.

In the Spanish–American War Dr. Steenberg served with the Wisconsin National Guard in Puerto Rico. Returning to service as a medical officer in the World War, he served in Panama and at various army posts in this country both during and after the war.

When Dr. Steenberg retired in 1929, he was a captain flight surgeon, Army Air Corps. Since then he has lived in Milwaukee. He was a member of the American Medical Association.

Surviving him are his widow; a brother, Fred G., Fond du Lac; two sons, David K., Milwaukee, and

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Gerald H., Westfield, N. J., and two daughters, Mrs. C. E. Turner, Falls Church, Virginia, and Mrs. J. A. Kelley, Green Lake.

Dr. Alexander J. Williams, Racine, who was born in 1873 in Racine, died on May 17 in a Racine hospital.

He was graduated from Rush Medical College, University of Chicago, in 1900. In college he was active in athletic events and was coach of the first football team of the Racine High School in 1898. During his early practice he was health officer in Racine, and in his late years until the time of his death he was city doctor.

He was a member of the Racine County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are a daughter, Mrs. Albert Stoffel, Richmond, Virginia; a son, Boyce R., Indianapolis, Indiana; four sisters; two brothers; two grandsons, and one granddaughter.

THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

The 1941 Year Book of General Surgery: Edited by Evarts A. Graham, M. D., professor of surgery, Washington University School of Medicine; surgeon-in-chief of the Barnes Hospital and of the Children's Hospital, St. Louis. Cloth. Price $3. Pp. 768, with 349 illustrations. Chicago: The Year Book Publishers, Inc., 1941.

As in previous years, this "Year Book of General Surgery" needs no recommendation. The articles are abstracted well, and the editor has presented material that will be of practical value to both the general practitioner and the surgeon. The volume presents for the first time the work on the parenteral use of amino acids, and discusses the treatment of war wounds. A. R. C.

Woman's Personal Hygiene: Modern Methods and Appliances: By Leona W. Chalmers. Foreword by Winfield Scott Pugh, B. S., M. D., New York City. Cloth. Price $2. Pp. 192, with 32 illustration. New York City, Pioneer Publications, Inc., 1941.

This book presents definite information to the lay woman in language which she may understand easily. Most of the facts given are authentic and meet with the modern medical approval. The purpose of the authoress could have been accomplished as well with omission of some of the advertising material. M. J. T.

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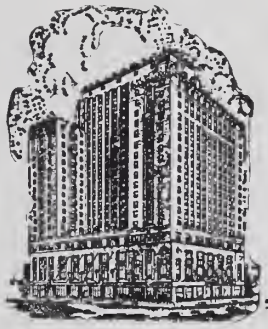

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BOOK REVIEWS—Continued

First Aid in Emergencies. By Eldridge L. Eliason, A.B., M.D., Sc.D., F.A.C.S., professor of surgery, University of Pennsylvania School of Medicine; professor of surgery, University of Pennsylvania Graduate School of Medicine; surgeon, University of Pennsylvania, Presbyterian and Philadelphia General Hospitals. Ed. 10. Cloth. Price, $1.75. Pp. 260, with 126 illustrations. Philadelphia: J. B. Lippincott Company, 1941.

This book, intended primarily for the layman, is written in a clear and concise manner. The chapters devoted to transportation of patients, bandaging, bleeding, heat exhaustion and freezing, unconsciousness, convulsions, suffocation, poisons and medical emergencies are excellent. However, the good discussion on wounds, foreign bodies, dislocations, fractures and abdominal pain is marred by the fact that the author frequently leaves the realm of First Aid and enters into therapeusis. This information in the hands of untrained men will do much more harm than good. In this day with modern conveyances a doctor is within calling distance in remote localities. This book would be of value as a text for military aid, but the reviewer does not believe the extensive discussion on therapeutics is necessary in civil life. A. R. C.

The 1941 Year Book of Industrial and Orthopedic Surgery. Edited by Charles F. Painter, M. D., orthopedic surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital, Boston. Cloth. Price $3. Pp. 432, with 353 illustrations. Chicago: The Year Book Publishers, 1941.

The Year Book of Industrial and Orthopedic Surgery is a collection of abstracts of all of the more worth while literature of the past year in these fields, clearly written in a small handy volume. It is of interest to the practitioner, the specialist, as well as the so-called general practitioner. It aids the former by presenting to him in one volume the type of work his fellow specialist is carrying out, and he is able to keep abreast of the times with a minimal expenditure of time. The latter is benefitted by the short concise presentation of the material contained in any specific article; thus, in reference work, he is able to hand-pick the articles which he wishes to read.

Many new concepts are brought out in some of the papers and from the summary one is able in most cases to determine beforehand whether or not the article is worth reading. Throughout the book are scattered many so-called "pearls" dealing with the pathology, diagnosis and treatment of the diseases. One gains a great deal from simply reading the book without going to the original articles themselves.

Of especial interest are the articles dealing with the treatment of war wounds. One's attention is called to the remarkably good results which the simple treatment of large deep lacerations and compound fractures bring—wider incisions, debridement, packing with vaseline gauze and application of plaster, after reduction of the fracture, if one is present. In one series of cases this was done without administration of either antitetanus or antigas gangrene serum, with no untoward results. This is certainly worthy of much deeper investigation. The section dealing with the treatment of acute osteomyelitis reflects the controversy of the more respected authorities on the subject of the advisability of early or late surgery. Topics of the two types mentioned stimulate within each of us an altercation which of necessity leads to further and more minute study of the particular subject. It appears to me that this is the justification of such books and the reason why they should be more widely read. S. C. R.

Stethoscopic Heart Records. By George D. Geckeler, M. D., associate professor of medicine, Hahnemann Medical College and Hospital of Philadelphia. Set M 600. 7 Records. Price $12.75. Bridgeport, Conn.: Columbia Recording Corporation, 1942.

These stethoscopic heart records are a faithful reproduction of heart sounds, murmurs and arrhythmias which are of value in teaching and as a "brush-up" for the general practitioner who in the intervening years may not have had the opportunity to keep himself well posted on the various murmurs and arrhythmias. The only criticism offered is that the ringing aortic second sound recorded is not ringing but tambour-like in quality. The arrangement of the recordings is very good and because of the ease and control of usage they should prove of great value in a teaching institution as well as a physician's office. H. H. S.

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A Primer on the Prevention of Deformity in Childhood. By Richard Beverly Raney, B. A., M. D., associate in orthopedic surgery, Duke University School of Medicine; and attending orthopedic surgeon, Watts Hospital, Durham, North Carolina. In collaboration with Alfred Rives Shands, Jr., B. A., M. D., medical director, Alfred I. du Pont Institute of The Nemours Foundation, Wilmington, Delaware; visiting professor of orthopedic surgery, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania. Cloth. Price $1. Pp. 188, with 88 illustrations. Elyria, Ohio: National Society for Crippled Children in the United States of America, Inc., 1941.

In this handbook, the author has executed a piece of work sorely needed. As stated in the preface, public health work and instruction have decreased the incidence of many of the diseases which until one or two generations ago were responsible for most of the deformities in children. Further, earlier diagnosis of these diseases should receive its due credit. However, these diseases we still have with us and Dr. Raney's book fills the need of a short concise work which will explain the deformity, list the etiology, and present a working principle for a suitable brace.

There are many excellent illustrations of both the deformity under consideration and the brace in position for correction. So that there can be no misunderstanding of the context, simple terms are used throughout the book and those orthopedic terms which are necessarily used are fully explained in the glossary at the end. S. C. R.

The Principles of Neurological Surgery. By Loyal Davis, M. S., M. D., F. A. C. S., Ph. D., D. Sc. (Hon.), professor of surgery and chairman of the Division of Surgery, Northwestern University Medical School, Chicago, Illinois. Second edition. Cloth. Price $7. Pp. 503, illustrated with 154 engravings, containing 298 illustrations and 5 colored plates. Philadelphia: Lea & Febiger, 1942.

The author has stated that his purpose in writing this book was to provide easily assimilable facts which will give the general practitioner and medical student an accurate concept of neurologic surgery. In many respects he has succeeded admirably. The chapter on peripheral nerve injuries is one of the most lucid, helpful, and concise treatments of this subject that I have read. This good perspective is not, however, maintained throughout the book, for some subjects are dealt with more in detail than is necessary for the average medical student or general practitioner, and, on the other hand, not sufficiently exhaustively to be of value to the neurologist or neurosurgeon. There are few details of surgical technique which would be of value to the general surgeon who is faced with the necessity of doing the occasional neurosurgical operation.

The illustrations are numerous and of good quality and the references to the literature are well chosen. On the whole, this book is a good survey of the field of neurologic surgery and can be highly recommended. T. C. E.

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BOOK REVIEWS—Continued

Endocrinology, Clinical Application and Treatment. By August A. Werner, M. D., F. A. C. P., assistant professor of internal medicine, St. Louis University School of Medicine; associate physician, St. Mary's Group of Hospitals; Physician Endocrine Clinic, Desloge Hospital and the Missouri State Hospital No. 4, Farmington, Mo. Ed. 2, thoroughly revised. Cloth. Price $10. Pp. 924, illustrated with 327 engravings and a colored plate. Philadelphia: Lea & Febiger, 1942.

This second edition is definitely enlarged as compared with the earlier edition of the same work. It represents an attempt to move from the descriptive type of endocrinology of the 1920's to the methods of precision based on laboratory studies of endocrine activity. The book is replete with illustrations. It presents in very interesting style the personal interpretations of the author. A valuable contribution is the special chapter on hyperostosis of the internal frontal bone. E. L. S.

Hughes' Practice of Medicine. Revised and edited by Burgess Gordon, M. D., clinical professor of medicine, Jefferson Medical College; director and physician-in-charge, Department for Diseases of the Chest, Jefferson Hospital; assistant physician, Jefferson Hospital; physician, Pennsylvania Hospital; visiting physician, the White Haven Sanatorium, consultant in tuberculosis, Philadelphia State Hospital; consulting physician, Frederick Douglass Memorial Hospital; Lieutenant Colonel, Medical Reserve, Base Hospital No. 38. Ed. 16. Cloth. Price $5.75. Pp. 791. Philadelphia: The Blakiston Company, 1942.

This book is intended to present in concise form the clinical aspects and treatment of disease. This new sixteenth edition has several additions to bring it up to date.

There is a wide range of material presented including subjects not usually found in a book on practice of medicine. There is a very good chapter on legal aspects of medicine, also a section on the more common skin conditions. Some techniques such as that of counting of blood are included. All the discussions of the many medical conditions are brief. The arrangement of subject material is satisfactory.

As is almost inevitable when terseness is so emphasized, certain undesirable dogmatic statements creep in. For example, the definition of leukemia as a disease in which there is an enormous increase in the number of white blood corpuscles is not accurate, for leukemia is as much leukemia with a moderately increased or normal leukocyte count. Similarly in the discussion of causative factors in bronchiectasis, complete accuracy is lacking, and the etiologic role of atelectasis is ignored. On the same page, 489, there is a minor error in stating that the bronchial dilatations are cylindrical, *uniform* when fusiform is meant, and saccular. All in all, there are few errors of this type, but one is distracted by them.

The book is beautifully bound and of handy size. The type (8 pt.) is smaller than that usually found in text books but readable. There are very few illustrations. The particular value in this nice book, it seems to the reviewer, is its conciseness, thus furnishing a handy, convenient reference book for those in the practice of medicine. It is less suitable for students. O. O. M.

GROSSMAN—NONTRAUMATIC RUPTURE OF A PREVIOSLY NORMAL SPLEFN AND ITS MEDICOLEGAL ASPECT

(Continued from page 482)

Conclusions

1. A case of nontraumatic, nonchronic pathologic rupture of the spleen is reported.

2. A more workable classification of spontaneous splenic rupture is advanced.

3. A series of embolic phenomenon from a distant apparently benign focus, contracted in industry, is presented.

4. The possible industrial aspect of splenic rupture is emphasized.

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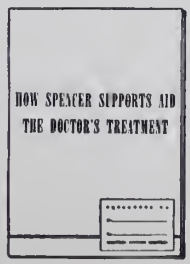

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A supplement to The Wisconsin Medical Journal Vol. 41 No. 6

JUNE 1942

CHRIS L. CHRISTENSEN

Introducing Dean Christensen

IT IS my privilege as president of the State Medical Society of Wisconsin to present to our members the first contributor to this educational section on nutrition, our first line of home defense. Mr. Chris L. Christensen, dean of the University of Wisconsin College of Agriculture and director of the Agricultural Experiment Station and Agricultural Extension Service since March, 1931, is well known both to Wisconsin citizens and to the Nation. He was secretary of the Federal Farm Board from 1929 to 1931, and for five years previous to that he was head of the Division of Cooperative Marketing, Bureau of Agricultural Economics, U. S. Department of Agriculture.

After serving in World War I and receiving his Bachelor of Science degree from the University of Nebraska, he was research fellow of the American-Scandinavian Foundation to Denmark to study agricultural economics and cooperative agriculture in 1921–1922. Mr. Christensen did graduate work in economics and marketing at the University of Copenhagen and the Royal Agricultural College, Denmark, 1921–1922, as well as in economics and business administration at Harvard University, 1923–1924. In 1937 the University of Nebraska conferred on him an honorary degree, Doctor of Agriculture.

While studying and doing research in the Scandinavian countries, Mr. Christensen gave special attention to the economic development of Danish agriculture and cooperative organization, later preparing a publication on "Agricultural Cooperation in Denmark," which has had unusually wide distribution among farmers in the United States and Canada, and also has been translated and distributed in several foreign countries. Mr. Christensen is also author of numerous other articles on agricultural problems.

In 1922 and 1923 Mr. Christensen was employed in the capacity of research agent in the U. S. Department of Agriculture to investigate agricultural marketing and cooperative organization among farmers in Denmark, Sweden, Norway, Finland, Germany, Czechoslovakia, Switzerland and England. As a member of the staff of the Bureau of Agricultural Economics of the U. S. Department of Agriculture from 1924 to 1926, Mr. Christensen was engaged in directing and conducting research in farm cooperative organizations, marketing and distribution of agricultural products.

When Congress passed the Federal Cooperative Marketing Act in 1926, creating the Division of Cooperative Marketing in the U. S. Department of Agriculture, he was put in charge of the division. Mr. Christensen was one of the leaders in the organization of the American Institute of Cooperation in 1924 and took an active part in the 1925 and 1926 summer sessions which were held at the Universities of Pennsylvania and Minnesota under the auspices of the American Institute of Cooperation.

When the Federal Farm Board was organized in 1929, Mr. Christensen was selected as its first executive secretary, serving in this executive capacity for nearly two years. During this initial period Mr. Christensen was entrusted with large administrative duties and executive responsibilities in the organization of the Federal Farm Board's various departments, selection of personnel and operating policies and procedures.

We are fortunate to have Dean Christensen prepare this article for *The Wisconsin Medical Journal.* His work with problems of the farmer, and his intimate knowledge of the farmer's value to his community and to his country, qualify him as an outstanding expert and authority in his chosen field. We welcome Dean Christensen to the columns of *The Wisconsin Medical Journal* with a truly deep appreciation of his kindness.

—GUNNAR GUNDERSEN, M. D., *President*
State Medical Society of Wisconsin

Butter in National Health

By CHRIS L. CHRISTENSEN

Dean, College of Agriculture; Director, Agricultural Experiment Station
University of Wisconsin

BUTTER is a tasty, highly concentrated food product, with great nutritional values. It furnishes large quantities of heat energy, ranking far ahead of sugar in caloric value, and it is an excellent source of certain vitamins and accessory food substances which promote the growth, health, and well-being of man. As butter is easily and almost completely digested, these nutritional substances are made available for utilization by the human body.

Those are some of the chief reasons that butter is regarded by scientists as a valuable addition to any menu, and those are the reasons given by Conrad Elvehjem, nationally known biochemist at the University of Wisconsin and member of the Food and Nutrition Committee of the National Research Council, for regarding butter as a good food product for all ages.

Wisconsin Has High Standard

Although butter is uniformly good as a food, different samples vary in composition and quality, according to Elvehjem. Butter produced under different conditions may contain anywhere from 70 to 90 per cent fats. State laws, however, protect the consumer by requiring that butter for public sale must contain at least 80 per cent fats. The natural color of butter may vary from deepest yellow to almost white.

Vitamin A and Carotene

While vitamin content may also vary in different butter samples, vitamin A, the fat-soluble food substance necessary for the prevention of certain types of skin disorders and eye conditions such as night blindness and xerophthalmia, is found in all butter. Its occurrence in nature is associated with the yellow plant pigments, the carotenes, which are converted in the human or animal, yielding vitamin A.

The measurements of the vitamin A content of butter are complicated by the vitamin A-carotene relationship.

Butter with a high carotene content, and consequently bright yellow in color, may have a low vitamin A content, and still have a high potency, since carotene is converted to vitamin A in the body. Vitamin A itself is a colorless, oily substance, and butter with a high vitamin A content, and virtually colorless, has a low carotene content. Therefore, while a good natural dark yellow tone is a good indication of the presence of carotene, absence of that color does not mean that the butter is deficient in total vitamin A.

June Sets Pattern For Winter Feeding

A change in dairy ration will alter the vitamin content of the butter produced. By taking dairy animals off pasture a source of carotene is removed from their diet, and the vitamin A value of the butter produced from their milk drops off as much as 50 per cent. However, dairymen, now recognizing this fact, are taking measures to prevent this decrease by supplementing the winter feeding with rich, green alfalfa hay or other products high in carotene.

Butter as a Source of Vitamin D

Vitamin D is also present in butter, and while it may vary in amount in different samples of butter, all butter is a fair source of this vitamin which is so essential to the bony structure. The natural source of vitamin D, of course, is sunlight, and thus it has been found that butter produced during the winter months from the milk of animals deprived of sunlight and pasture is lower in vitamin D content than is butter produced during the summer months when the animals are on pasture and in the sunlight.

Physicians recognize, of course, that fish liver oils are far superior to butter in supplying the antirachitic factor so important in preventing rickets and osteomalacia. However, butter furnishes an auxiliary supply of

vitamin D, and artificial enrichment of it by ultraviolet rays makes it an even better source.

New Butter Factor

Most recent research has revealed a new factor in butter, as yet unnamed. The substance has never been isolated, and although work is now going ahead rapidly on it, all that is yet known is that young animals grow much better when supplied with it than when fed only vitamins A and D and supplementary fats of a non-dairy origin.

Digestibility of Butter

The digestibility of butter is uniformly good. All fats with a low melting point are easy to digest, and butter is in this class of fats, ranking second only to fish liver oils in ease of digestion and completeness of utilization. Besides, butter on digestion yields fatty acids of low molecular weight, which play an important role in the process of metabolism.

Human Requirements

About two ounces of good butter daily will supply the vitamin A requirements of an average child, and two to three ounces of butter with a pint of whole milk daily will be quite adequate for an adult's vitamin A requirements. Butter is not to be depended upon alone for an adequate supply of vitamin D, although its value as an accessory source of vitamin D is very important. Just what amount of the newly discovered "butterfat growth factor" is required for normal growth, and to what degree butter is adequate in supplying it, have not been established. However, research indicates that butter may prove adequate to supply man's requirements of this substance.

The importance of the nutritional value of butter was not always as fully recognized as it is today. Scientists had known for years that fats are needed for human growth, but until the early part of this century, when E. V. McCollum made his first studies at the University of Wisconsin, little else was known, and no attempt had been made to determine which fats are needed and why.

Orientals Found Way to Prevent Beriberi

It was through a sequence of experiments performed over a period of more than a quarter century that there was ultimately brought to light the present, though yet incomplete, knowledge of this unnamed factor present in butter, which we do know to be essential to growth. Included in this series of investigations was the search for the cause of beriberi.

When beriberi and other nervous disorders were taking their yearly toll of human lives in Japan in the 1870's it was suspected that this disease was the result of some undiscovered micro-organism. That suspicion was substantiated by the fact that the disease appeared among the low-class fishermen, farmers, coolies, and river-dwellers, who lived in crowded areas in Japanese villages. The disease took its biggest toll immediately after heavy floods, and this again confirmed the bacterial theory, since almost all diseases caused by bacteria make their heaviest ravages in flood time when drinking water and food are apt to be polluted.

When the disease broke out, during the Russo-Japanese war, and despite isolation, spread rapidly among the sailors in the Mikado's navy, a more concentrated effort was made to determine the nature and cause of the disease. Reference to earlier medical records revealed that a Dutch scientist named Eijkman, working in the Dutch East Indies, had made experiments on pigeons, producing a disease not unlike beriberi. Eijkman had produced this disease spontaneously in birds isolated from any chance of contagion, and his final conclusions were that the disease was a result of feeding the pigeons polished rice. This lent impetus to the search being made by the Japanese admirals, since the staple food on their navy's ration was polished rice. With a change in their ration to unpolished rice the disease subsided, and thereafter the sailors were served unpolished rice.

While this brought to light an important feature of the disease, it still had not revealed the fundamental cause of beriberi. Scientists began a search for the element, apparently present in the outer shell of unpolished rice, which prevented beriberi, and

the first suspect was phosphorus. Fraser and Stanton discarded that view, however, when they found that an extract from rice polishings containing only 15 per cent of the total phosphorus would still prevent beriberi, while the remaining 85 per cent phosphorus extract had no control over the disease.

Meanwhile Funk, in Poland, had isolated a compound from rice polishings, which within a few hours restored the ability to fly to a pigeon, paralyzed by neuritis. However, he had neither identified nor analyzed his new "vitamin."

Wisconsin Investigations Fundamental

At this time E. V. McCollum, a young Yale graduate, was just entering the field of nutritional investigation at the University of Wisconsin, working under the direction of Professors E. B. Hart and the venerable Stephen Moulton Babcock. While taking his "apprenticeship" at the Wisconsin Experiment Station, young McCollum read with interest these reports of the search for the food factors so vital to life and good health.

One item in particular interested him; the story of the German scientists who had fed rats a diet completely balanced but containing phosphorus only in the inorganic state. The German scientists had reported that their animals died for the lack of this phosphorus, but McCollum questioned their findings. He tried the test himself, and discovered that the rats he fed lived and grew to be fat and healthy. One animal nearly doubled its weight in less than two months on this same diet, which the German biochemists had claimed was fatal to their rats.

Osborne and Mendel, American scientists, trying a similar experiment and following the procedure of their tests, had the same results as the German scientists. This was perplexing to McCollum, as well as to other scientists, and he proceeded to determine wherein his experiments differed from those of the other workers. He compared the rations used, and found that in his own ration he had used butter for the source of fat in the diet, while the other two experimenters had used lard. From this McCollum learned that butterfat is essential to growth and health, and tests conducted later by himself and a co-worker, Margaret Davis, verified this conclusion. Osborne and Mendel worked independently, and shortly after McCollum and Davis published a report in June, 1913, they told of a butterfat and egg yolk factor which greatly promoted growth, revealing that certain eye conditions and skin disorders could be traced to a deficiency of that butterfat factor.

One Vitamin or Two?

At first scientists wondered whether McCollum's discovery involved the same element which Funk had found in rice polishings. However, experiments were performed, and rats from the same litter placed side by side, one living on a diet which included only rice polishings, and the other on a diet including butterfat alone, made minimum growth gains. Only the animals which received both compounds were strong and healthy. These results indicated that there were two factors involved. In 1916, McCollum further clarified the matter by naming the element which Funk had discovered vitamin B, and the butterfat factor, vitamin A.

Vitamin B, then believed to be a simple compound, but now revealed to be a complex collection of separate vitamins, appeared in green vegetables, eggs, nuts, and liver. That is the reason beriberi had followed floods, which had destroyed vegetable gardens and poultry houses, leaving only polished rice and fish for the people to eat.

Tests performed to determine the source of vitamin A had revealed its presence in quantity in the fish liver oils and in butter. Later investigations to determine the source of vitamin D revealed that butter was also fairly rich in the sunshine vitamin.

Butter Contains a "Growth Factor"

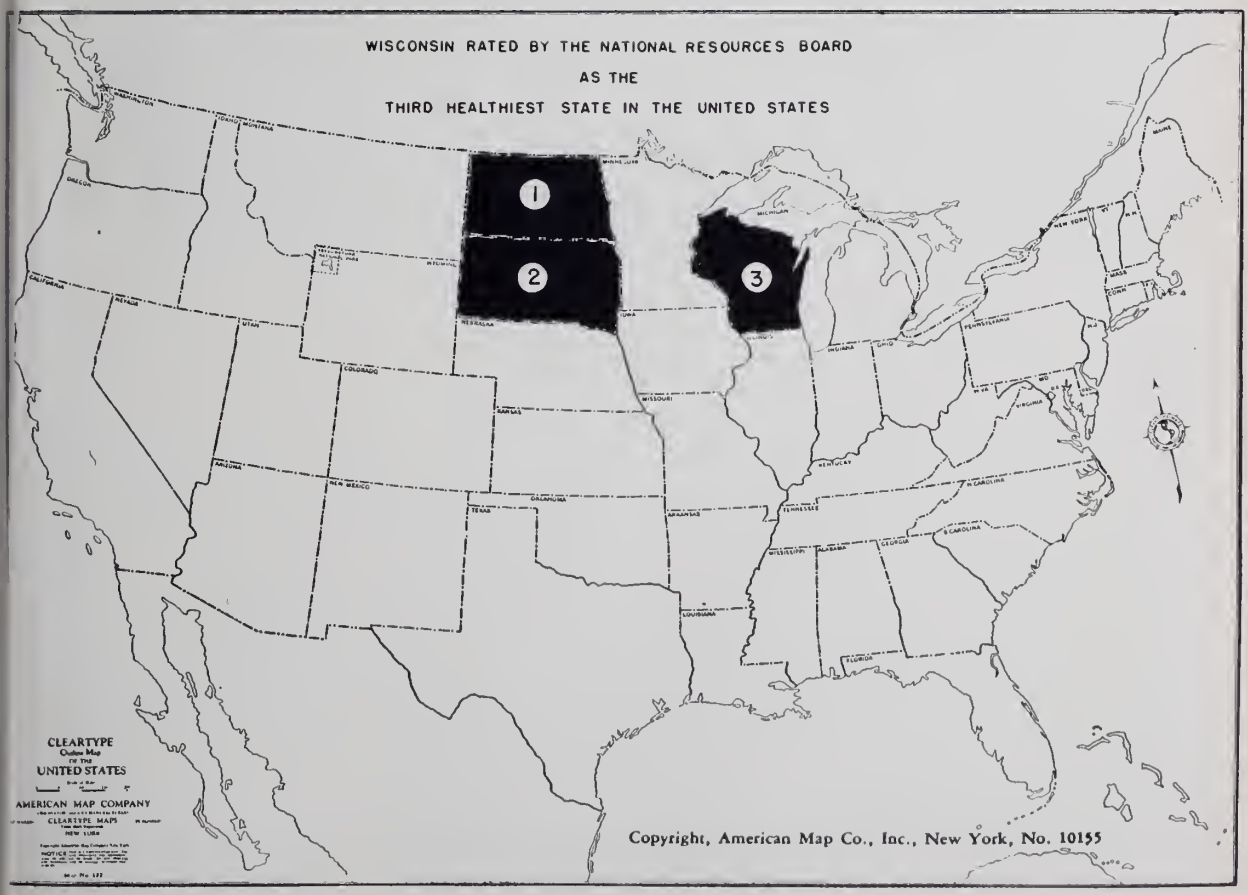
After these experiments the scientists were satisfied that they knew all there was to learn about butter, until Edwin Bret Hart, University of Wisconsin biochemist, began some additional experiments. Some of his experiments, together with other work carried on in the biochemistry department, con-

vinced him that there was something yet unrevealed in butter; that there was an accessory growth substance which did not occur elsewhere. This factor is as yet unnamed.

Research workers began work on the problem and obtained evidence that this factor exists, and so far tests have not shown its presence anywhere except in animal fats. At this time experiments are being made to isolate and identify the factor, and after that more tests will determine its source and what quantities of it are needed for normal growth. Deficiency in what the scientists now call the "butterfat growth factor" shows its greatest effect in newborn animals. The new growth factor is no known compound, but is some new type of saturated fatty acid, the presence of which encourages normal growth and development, and a deficiency of which results in poor health and stunted growth.

Butter, therefore, performs an important part in the promotion of growth and good health by supplying heat energy and essential vitamins. Its potentialities are not yet fully revealed, but what we know of butter justifies the claim that it is not only an excellent but an essential food for growing children, and that it is a tasty and healthful food for adults of all ages.

Wisconsin is Accorded the Distinction of Being Rated as the Third Healthiest State in the United States



Introducing

Walter V. Price and Catherine J. Personius

THAT Wisconsin is America's Dairyland would, in itself, be no justification for emphasizing the value of dairy products in this series on nutrition, the first line of home defense. But ample justification is found in the enormous food value which dairy products supply, and in the fact that Wisconsin leads America in the science and practice of dairying.

The two authors of this month's article, "Wisconsin Cheese," are Mr. Walter V. Price, an expert in the fields of cheese manufacture and cheese analysis, and Miss Catherine J. Personious, a careful and capable worker in foods, and at present conducting research on cheese.

Mr. Price took his undergraduate and graduate work in dairy industry at Cornell University. Then, as a member of the faculty, he worked with one of America's greatest dairy scientists, Lucius L. Van Slyke, in the authorship of "Cheese," the standard textbook in that field of dairying.

Mr. Price entered Cornell in 1914, took a couple of years off for service in the United States Navy during World War I, and received his B. S. degree in 1920. He earned his Ph. D. degree in 1925. During leaves of absence from Cornell he also gained valuable experience in the employ, first as a workman and later as manager, of a dairy condensery, market milk plant, and ice cream factory.

By 1927, Mr. Price earned the rank of full professor at Cornell. In 1928, he came to Wisconsin as full professor in the dairy industry department. Since then he has directed research and done a great deal of experimental work himself, along with teaching and the writing of a number of technical papers on dairy manufacture.

Miss Personius, too, has a rich background in research work along the lines of foods, at present being in charge of food technology research at the University of Wisconsin. She is directing, among other experiments, the examination of the cooking qualities of various types of cheese.

Miss Personius took her undergraduate work at Elmira College in New York State, and on her graduation in 1925 she continued for two years on the faculty of the college. Then, after a year of graduate work in home economics education at Columbia, Miss Personius went to Hampton Institute to teach courses in foods.

She went to Cornell as a faculty member in 1930, and then did part-time study, earning her Ph. D. degree in 1937. During the summer session of 1936 she taught a course in experimental foods at the University of Minnesota, but on completion of her doctorate requirements in biological and physical chemistry and bacteriology at Cornell she stayed with that university as assistant professor of foods. Then in 1940 she came to Wisconsin to teach and to conduct research.

Her present research work is notable as an example of applying the principles of physical and colloidal chemistry to a study of foods.

—STEPHEN E. GAVIN, M. D., *Chairman of Council*
State Medical Society of Wisconsin

IN THIS BUILDING in 1890 Wisconsin set a pattern for the rest of the nation, demonstrating how the abstract findings of science could be applied to dairying for the benefit of the whole industry. Here practical dairymen met half a century ago in the University of Wisconsin's dairy school, the first ever held in America.

The history of this state's dairying begins more than 100 years ago when Vermont Yankees, stocky Germans, thrifty Scandinavians, and democratic Swiss brought their herds across the continent, cleared their Wisconsin woodland acres, and took up the business of farming.

The second page in that history was written when the University of Wisconsin, recognizing the part that science must play in progress, undertook the scientific analysis of the dairy industry and its techniques. That page is brightened by such discoveries as the universally accepted Babcock test for butterfat, the Babcock–Russell cold-cure process for cheese, which is the foundation of the modern cheese industry; the application by H. L. Russell of the bovine tuberculin test; and the extensive research work of such others as Farrington, Hart, Steenbock, Elvehjem, Weckel, Hastings, Sommers, and Price.

But the brightest page of all was when these men realized that, whatever practical virtues a certain scientific discovery may appear to have in theory and in the technical journals, such a discovery is of no immediate practical value until it can be extended to actual existing problems. Science itself is not an end, but a means to an end.

So, to apply these scientific studies which the University laboratories were making, the college convened its first annual dairy school in the winter of 1890 to teach to practical farmers and dairy manufacturers the practical aspects of laboratory work.

Enrollment in the dairy school has grown. That, in itself, is no mean tribute to the men who, by their foresight, extended their research findings right to the dairy farm. No less a tribute is the fact that other colleges and universities all over America have accepted the dairy school idea.

But the greatest tribute of all is the fact that this state, its college, and its dairymen are universally accepted as the American pioneers of applied dairy science.

Wisconsin Cheese

By WALTER V. PRICE, and CATHERINE J. PERSONIUS*
University of Wisconsin, Madison

CHEESE is one of the most important single foods in this period of international emergency. Not only is it a good nutrient for American consumers, but now that shipping losses and the course of the war have limited the tonnage of food that can be sent abroad, Wisconsin's number one dairy export has become Britain's number one food import.

Great Britain can bring in only such foods as carry greatly concentrated protein, energy, and vitamins, because every pound of food shipped across treacherous waters must be loaded with health and nourishment. And the requests and orders from abroad re-emphasize the importance of cheese as the one food which, more than any other, will fill the bill.

That view should confirm for Wisconsin men and women the importance of the dairy state and its food products in world affairs. But more than that, it should force Wisconsin people to re-examine the nutritive values of those products. When people several thousand miles away put cheese first on their national diet, it's about time America's dairyland found out why.

Cheese is a Condensed Food

Most people have read, from time to time, fanciful predictions that soon man will get all his food in capsule form. Most thinking people are sure that the goal is a long way off, and science is quite positive that the aim is not to be desired. But science has no such doubt about cheese. For despite the fact that it approaches very closely to the aim of concentration of food values, it has the approval of medicine, biochemistry, and nutrition. All three fields agree that it is a valuable concentrated food supply.

What's more, the men of the scientific laboratories are not alone in their recognition of the worth of cheese. All over America; all over the world, in fact, its popularity as a table delicacy is unquestioned.

Cheese is the internationalist of foods. It is not limited to a single state, nation, or even continent.

Down the list of varieties are such picturesque types as Monk's Head, produced by the holy men of Bern, Switzerland; Abertam, a Bohemian sheep's milk cheese; Banbury, from England; Alpin, from the heights of the French Alps; Chhana cheese from Asia; Dutch Commission cheese; Portuguese Alemtejo; Italian Chiavari; Hungary's Damen; Scotch Dunlop; Finnish Egg cheese, produced from fresh milk and eggs; Danish Gislev; Austrian Gray; Ilha from the Azores Islands; Silesian Josephine; Lapland cheese; Buttermilk cheese; Mesitra from the Crimea; Swedish Mysost; California Jack cheese and Wisconsin Brick; Pineapple, so-called from its shape; Porto Rican Queso du Puna; Swedish Reindeer Milk cheese; Argentine Tafi; Mexican Tuna; Tworog from Russia; Swiss Ziger; and Trappist cheese, originated in Bosnia in the Trappist monasteries.

Cheese Varies in Many Ways

These are all variations of some of the original cheese types, and yet each of them differs slightly in shape, size, and curing qualities. Timing, weight, test of milk used, type of milk employed, and length of curing, are all factors in the quality of cheese produced. Even the size of a cheese may vary its quality.

All these are easily variable items, and they have a profound effect on the way the final product tastes. But one thing does not change in the whole process; a good job of cheese manufacture will produce a cheese that possesses much of the nutrients that the milk contained, all securely sealed in the final product.

Proteins and Energy? Eat Cheese

Cheese is not a by-product. It is, on the other hand, a concentration of almost all the food values which make milk itself a "must"

* As told in an interview with Bryant Kearl.

on any menu. Most of those values carry through to cheese, which, though it is greatly changed from milk in composition and consistency, in the final analysis supplies much of the heat and energy, substantially all the growth-promoting proteins, and apparently all the essential vitamins which characterize milk itself. The cheese has lost most of the sugar, ash, and albumen which were contained in the milk, but the fat and other protein nutrients are almost completely retained.

To see just what happens to the original milk and its food components, let's follow through the cheesemaker's process.

He starts with whole milk—milk that tests, let us say, 3.5 per cent butterfat. That means that 100 pounds of milk will contain 3.5 pounds of pure fat, the most efficient of the food stuffs as a source of energy; as well as about 87 pounds of water; 2.5 pounds of casein, the complete dairy protein; 0.5 pound of added protein in the form of albumen; and about 6 pounds of sugar and ash.

In his process the cheesemaker first eliminates much of the water, and with it he loses most of the sugar, ash and albumen. But he retains about 3.2 pounds of fat (a negligible loss of about 5 ounces); 2.3 pounds of casein, the dairy protein (a loss of only 3 ounces of that nutrient, too, in the whole manufacturing process); and a little over 0.5 pound of sugar and ash.

Minerals and Vitamins? Eat Cheese

Although much of the ash is lost, the nutritionally important minerals, calcium and phosphorus, are carried through in quantity from milk to cheese. An ounce of good cheddar, yielding a little over 100 heat calories and more than 6 Gm. of protein, has at least ¼ Gm. of calcium, and ⅕ Gm. of phosphorus. Two and a half ounces of cheese daily amply fill an adult's calcium needs, and go a long way toward supplying phosphorus requirements.

Nutritionists recognize that it requires a very carefully selected diet to supply an adult's calcium needs unless cheese or milk constitute a part of that diet.

SCIENCE PROVES THERE'S HEALTH IN CHEESE

Cheese helps build stronger muscles—Protein abundantly provided.

Cheese helps build firmer bones—Contains calcium and phosphorus.

Cheese furnishes heat and energy—Whole milk cheese is a rich source of fat.

Cheese helps keep us well—Contributes vitamins for health and growth.

Cheese is a health food.

As for vitamins, the best surveys conducted to date show that vitamins A and D carry through almost unharmed in the process of converting whole milk to cheese. Virtanen and Kreula, Finnish scholars, report that vitamin A and carotene, from which vitamin A may be synthesized in the body, are both preserved, at least in Swiss cheese, during the manufacturing and ripening process. Balsamelli carried on more extensive studies with cheese samples of various types and ages to show that fresh, ripened, and pasteurized whole milk cheeses of all kinds may be a rich source of vitamin A and fairly rich in vitamin B_1 (thiamin). The League of Nations' Committee on Nutrition lists cheddar cheese as a good source of riboflavin as well, and that same committee puts cheese on the recommended diet for pregnant or nursing women as a source of proteins, fats, calcium, and vitamins.

Most milk used in cheesemaking contains only small amounts of vitamin D, and so cheese is not an exceptionally rich source of this vitamin.

At one time there was even some suggestion that cheese might be proportionately richer than milk in certain vitamins, either by its transformation of those vitamins in the curing process or by its creating a food product from which the body could synthe-

size added vitamin A. Both Davies and Moore of Cambridge disproved any theory of added vitamin value in cheese some years ago. They noted, however, that people might easily believe that theory, because whole milk cheese is such a concentrated food that its share of vitamins by weight is much greater even than that of the milk from which it comes.

Some Types of Cheese Use Skim Milk

It would be a mistake to assume that all cheese is produced from rich whole milk. Some varieties by their very nature require the use of skim milk, and some of the whole milk varieties of ripened cheese may be produced using skim milk. But this latter class of cheese gives itself away to a discriminating buyer, for it is usually rough, hard, rubbery, and lacks palatability.

Of the types of cheeses which are always made from separated milk, cottage cheese heads the list. It is generally produced from skim milk which has been soured by special cultures. But then fat is added to the curds, so that the completed process finds a pail of cottage cheese made up of about three-fourths water, a little less than one-fourth protein, about 4 per cent fat, and some of the minerals which were present in the milk. It should be noted that since cottage cheese is an acid-curd cheese, in its manufacture most of the calcium is discarded with the whey.

Other types of cheeses are also essentially produced from skim milk, with Neufchatel being the chief example. But in this variety, too, cream or whole milk are frequently added sometime during the process, so that it contains anywhere from 12 to 25 per cent fat in the final form.

Skim Milk Cheeses For the "Reducing" Diet

The skim milk cheeses, even with some small quantity of fat added, are healthful, easily digestible, and not especially fattening. Frequently people who are unable to handle much fat in their diet request unfortified cottage cheese or Neufchatel, and in that form, they get nutritionally complete proteins, but few calories. The skim milk cheeses do not contain vitamin A except when cream has been added to them during manufacture; in that case they are good auxiliary sources of the vitamin.

All the cheeses named so far (cottage cheese, Neufchatel, and enriched Neufchatel) are classified technically as "soft" cheeses. The class has several other representatives, too. Limburger and cream cheese are both soft cheeses, and both of them contain much of the original nutrients which make up the milk from which they are manufactured.

Cheese Comes in Three Classes

There are three general classes of cheese: "soft," "semi-hard," and "hard." In the division of semi-hard cheeses, Roquefort and brick are the best known in this country. One type of Roquefort which is made from a brittle, friable curd obtained from uncooked cow's milk further ripened by molds, was imported to this country at first under the name of "bleu cheese," the French name, and so is usually known as blue cheese in the United States.

Roquefort proper and blue cheese are produced by a similar process except that Roquefort itself is made up in part from sheep's milk.

Brick, which first achieved great popularity in Wisconsin, is a semi-hard cheese made from whole milk cooked and then ripened by bacterial action.

The main examples of the hard cheeses are Edam and Gouda, Cheddar, Swiss and Parmesan. Edam and Gouda are less important in this country than some of the other cheeses, but in some parts of Europe they are the staple cheese. Both are peculiar in that they ripen without forming the gas holes which appear in Swiss and a few other ripened cheeses of the "hard" class.

Cheddar is America's Staple Cheese

Cheddar is divided into several subclasses: English Cheddar, American, Danish, and others. It is the standard hard cheese in America, made from cooked whole milk which is compressed and ripened with bacterial action.

Swiss also belongs in a separate grouping of hard cheeses ripened by bacteria. They are characterized by large gas holes.

Parmesan is a cooking cheese of Italian origin and of minor importance.

The different types of cheese that have been listed here by no means exhaust the field. In most European countries each community has a definite set of names for varying types of cheese, and since even in a scientifically controlled laboratory it takes great care to keep cheese flavor uniform, the number of different flavors and colors and types of cheese in Europe is large, but not surprising. A Department of Agriculture bulletin by Doane and Lawson points out that there are probably not more than a dozen distinct types of cheeses, but minor variations and geographical differences boost the number of names to the hundreds.

Modern science has partially failed in giving due attention to cheese. It is one of the oldest foods known, yet scientific research has not emphasized its food value.

Science Still Studies Cheese

Certainly some questions have not been answered definitely. A few scattered tests have been conducted comparing the digestibility of different types of cheese, and one conducted by Moen recently on Norwegian Gouda seemed to indicate that the aged cheese is almost completely utilized (99 per cent) in the digestion process. But certainly the question has not been explored as thoroughly as it should be.

Nor does anyone know the exact content of certain B-complex vitamins in cheese. There is evidence that certain of the B-complex vitamins are present, but the task of measurement is not yet completed.

But though fewer nutritive studies have been made of cheese than of some other foods, each succeeding investigation reemphasizes its importance. Cheese supplies protein building blocks and energy, both in great concentration and in easily available form. It is a complete protein food, which means that it contains all of the essential amino acids which are necessary to support life and promote normal growth. It carries both vitamins and minerals. Along with milk it plays a major role in supplying calcium needs.

The important thing is that cheese is a rich, health promoting food. The claims long made for it, science is now able to authenticate, and new scientific discoveries can only add to the reputation it has justifiably acquired as a food for health.

SOME OF OUR HEALTH ACHIEVEMENTS IN WISCONSIN

Childhood is safer. More Wisconsin babies live than do European babies.

Over 99 per cent of babies are delivered by physicians. Less than 1 per cent of the babies in Wisconsin are born when a physician is not present.

Since 1910 nineteen years have been added to our average span of life.

Fewer typhoid deaths occur in Wisconsin than in any other state in the nation.

Motherhood is safer. More Wisconsin mothers live to care for their babies than do European mothers.

Many communicable diseases, such as smallpox and diphtheria, have been controlled through scientific efforts, and are now classified as medical curiosities.

Vegetables Are Vital

By MAY REYNOLDS
University of Wisconsin, Madison

First of all a teacher, and a qualified research worker as well, Mrs. May Reynolds has been for two decades one of Wisconsin's best-informed nutritionists. By reading, by research, and by continued study she has kept up-to-date on all the latest findings in the field of foods.

Mrs. Reynolds took her undergraduate work at Iowa State College, taught in secondary schools in Iowa, and then came to the University of Wisconsin to teach and to do graduate work for her M. S. and Ph. D. degrees.

She has directed some work on the protein value of canned peas, and at present her research covers other protein utilization studies, conducted on humans by means of nitrogen balance measurements.

She is a member of the research committee of the American Home Economics Association's foods and nutrition section, and a member of the executive committee of the Wisconsin Dietetics Association. She also holds membership in Sigma Xi, national scientific honorary society; Omicron Nu, home economics honorary society; and Sigma Delta Epsilon, national professional society of women in science.

Mrs. Reynolds teaches technical courses in nutrition and dietetics at the University of Wisconsin, and as a scientist who is well aware of the importance of certain protective foods in the diet she writes the following article.

—FRANCIS E. BUTLER, M. D., *President-Elect*
State Medical Society of Wisconsin

VEGETABLES do the task! In times like these, when America's future depends in a great part on our physical health, vegetables come into prominence as body builders, protectors, and regulators. Vegetables are not a cure-all. They do not supply all the requirements of the human body. But they have a place to fill, and they fill it well. They minister to certain wants which cannot be filled by such other foods as meats, sweets and cereals. They supply an ample share of man's dietary needs.

What are the dietary needs for a healthy body?

First of all, a healthy body must be built upon a healthy framework. That demands quantities of minerals, particularly calcium and phosphorus.

We get most of our calcium from dairy products, and phosphorus usually offers no particular problem, since a good normal diet supplies sufficient phosphorus. But offering some added calcium are such vegetables as cauliflower, lettuce, turnips, carrots and dried beans, and these same vegetables also offer a fair supply of phosphorus.

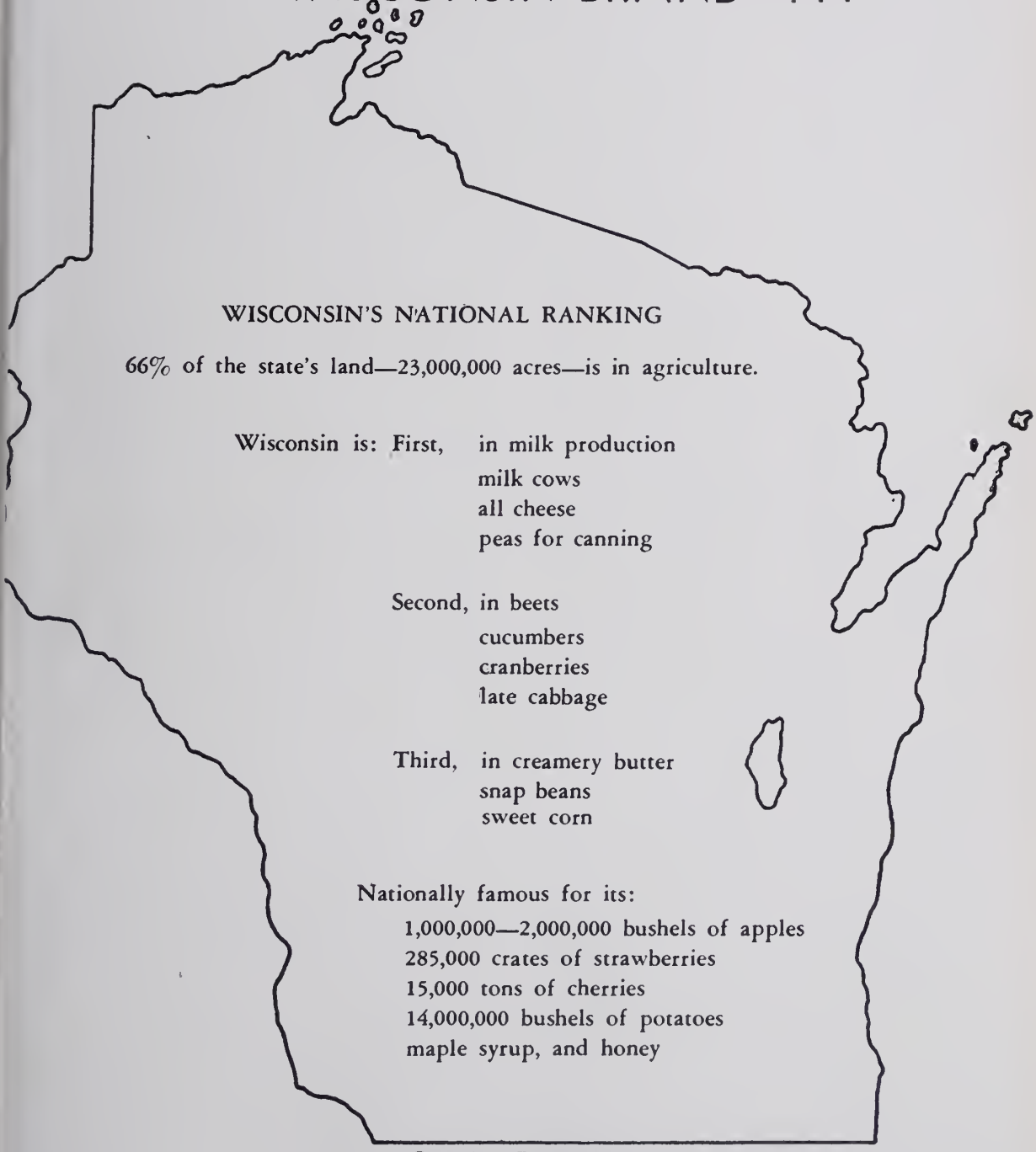
The body must have materials from which to produce well-formed muscles and organs, and foods rich in proteins are body builders. Here vegetables are weaker than many other foods, but dried peas and beans are a good source of protein, and other vegetables carry small quantities. It must be noted that the protein in these vegetables is not complete, and independently cannot support life and growth, but with other foods, they make a good contribution toward filling the protein needs.

Minerals Keep Up Body Morale

For healthy bodily organs and for a normal blood stream, minerals are again important. Phosphorus, mentioned earlier, is certainly a necessary nutrient in this respect, and when any deficiency in phosphorus occurs, an increase in the share of vegetables in the diet ordinarily will correct the fault.

Iron is equally vital and may be supplied by that old stand-by, spinach. The dinner-table motto, "Eat your spinach and get your iron," is not so far wrong as some people believe. Other green vegetables, too, are good sources, and while probably less than half of the iron in most vegetables is available for the body, still they furnish substantial amounts.

. . . "WISCONSIN BRAND" . . .



WISCONSIN'S NATIONAL RANKING

66% of the state's land—23,000,000 acres—is in agriculture.

Wisconsin is: First, in milk production
milk cows
all cheese
peas for canning

Second, in beets
cucumbers
cranberries
late cabbage

Third, in creamery butter
snap beans
sweet corn

Nationally famous for its:
1,000,000—2,000,000 bushels of apples
285,000 crates of strawberries
15,000 tons of cherries
14,000,000 bushels of potatoes
maple syrup, and honey

. . . One of the Three Healthiest States in the Union . . .

Another important mineral, copper, is found in small but significant amounts in most garden vegetables.

Vegetables are much weaker in the field of supplying energy to the body than are sugars, fats, oils, and meats, which adequately meet this need. But, the importance of vegetables to health is not measured by the energy they give (the exception to this rule is potatoes, which are important for fuel).

The Body Needs Regulators

The construction and maintenance of the body testifies that it is a well-planned machine, and as a machine we must recognize that it has certain functioning needs. It must, of course, have fuel to burn and to convert into energy. But it must also have lubricants and regulators. It must have proper timing and treatment to work at top efficiency.

Vegetables, supplying vitamins and minerals, solve these problems of regulation. Just as vitamins and minerals stabilize and encourage normal growth, and just as they help produce a healthy body, so they help to regulate the functioning of that body.

Minerals, for instance, help control digestion. They constitute a safety valve, too, which keeps an alkaline reserve in the blood stream to help neutralize excess acidity. Vegetables are important in supplying the minerals vital to the digestive process and in furnishing bulk and roughage, also important in digestion.

Many things enter into the question of healthy nerves. But an adequate mineral supply is one factor which helps regulate the functioning of the sensitive nervous system.

Vitamins have a regulatory function, too, and appetite, digestion, and the proper functioning of the nervous system are all partially dependent on adequate vitamins. Again vegetables are an important source of supply.

Those Vital Vitamins

Let's step over to that vitamin classification to see just what vegetables have to offer.

All green leaves and green vegetables such as spinach, lettuce, and chard, and most yellow foods such as carrots, squash, and sweet potatoes, contain carotene, which can be converted to vitamin A in the liver. Vegetables supplement the dairy foods, therefore, in supplying the first vitamin, A.

Next on the list is thiamin, also spoken of as vitamin B_1. Thiamin is the vitamin of morale, one of the B-complex vitamins which is important to nervous stability. Its chief sources are lean meats, particularly pork, along with whole grain products, whole wheat flour and whole wheat cereals. But fresh peas and lima beans are excellent sources, and cabbage, carrots, spinach, and lettuce are good sources of thiamin.

Riboflavin, another B-complex vitamin which affects nervous balance and the digestive process, is found to some extent in peas and beans, in leafy vegetables, and in lesser amounts in corn. Vegetables are not the best source of this vitamin, which can be obtained more efficiently from milk, lean meat and liver, but they are helpful in insuring the riboflavin supply.

Nicotinic acid is less plentiful in vegetables than in meats and meat products. Peas and beans are fair sources of that antipellegra factor, but other vegetables carry very small amounts.

Vitamin C is also important to nutrition, and here another vegetable comes into the picture. Tomatoes are one of the best economical sources of vitamin C, and their appearance in the diet is a guarantee of vigor and of resistance to infection. Cabbage is very high in vitamin C content, and spinach, lettuce, turnips and peas are good sources.

In supplying the sunshine vitamin, D, fish oils are important, and exposure to sunlight is also a factor. Vegetables are of small consequence in that regard, although the leafy vegetables contain a very little vitamin D.

Protective Foods Are Needed

If any major mineral or vitamin elements are missing, then the body falls into disrepair, for it cannot function smoothly and efficiently without these body lubricants and regulators. That is why E. V. McCollum, who isolated vitamin A when he worked at the University of Wisconsin almost thirty years ago, later designated the foods which

WHAT VEGETABLES DO FOR US

The Body Needs:			It Gets Them From:
ENERGY	Carbohydrates	Starches	*Potatoes and other starchy vegetables* Cereals
		Sugars	Sugar and syrup Honey and molasses
	Fats		Butter and cream Meat fats Cheese Other fatty foods
BUILDING AND REPAIR MATERIALS	Proteins		*Beans and peas* Meats Dairy products and eggs Cereals
	Minerals	Calcium	*Green vegetables* Dairy products
		Phosphorus	*Beans and peas* Meats Cereals (whole grain) Dairy products and eggs
		Iron	*Green vegetables* Meats and eggs Cereals (whole grain) Dried fruits
REGULATORY AND PROTECTIVE FOODS	Vitamins	A	*Green and yellow vegetables* Dairy products Fish liver oils
		Thiamin	Cereals (whole grain) Meat *Green vegetables*
		Riboflavin	Meats *Green vegetables* Milk and eggs
		Nicotinic Acid	Meats Whole grain cereals *Beans and peas*
		C	*Tomatoes and cabbage and other raw vegetables* Fruits
		D	Fish liver oils Dairy foods Eggs

supply mineral and vitamins as "protective" foods, essential to the health of the body.

McCollum's earliest protective foods were milk and green vegetables. Now the concept has been expanded to include fruit and eggs as well, and modern biochemistry recognizes that all these foods are protective and efficiency-promoting. But, vegetables are still near the top of the list.

Vegetables Are Not Fuel Foods

All classes of foods have certain characteristics. Sugars and fats, for instance, supply heat and energy. Meats are generally rich in proteins and in some of the B-complex vitamins. Breadstuffs, if milled from whole grain, supply thiamin and are also rich in protein and energy. But, vegetables have their role in nutrition elsewhere, a role as important as that of any other class of foods.

Vegetables do not have their greatest worth as a food for fuel. Their important function is that of a food for protection and for the greatest degree of health.

One other factor has not been considered in this study of the nutritional value of vegetables. Vegetables are low in calories, high in roughage. In other words, they can supplement a concentrated diet high in protein and calories, supplying vitamins and some of the bulk which is important to digestion.

They can also be used to advantage in a diet designed to reduce the caloric intake. For the reducing diet, lettuce, cabbage, and spinach are very valuable, because they give a good supply of certain much-needed nutrients; they offer bulk and yet they are low in calories and are non-fattening. While the leafy vegetables are outstanding in this respect, most vegetables have some value.

The Food Plan is a Year-Round Job

Another important point to consider in measuring the nutrient value of vegetables in the diet, is that they are available all year round at reasonably low cost. Root crops keep well in cellar storage, and other vegetables can be prepared by drying, canning, or bottling.

That brings us to a question which housewives frequently ask. What effect does canning have on food value?

THERE'S A USE FOR EVERY VEGETABLE AND A VEGETABLE FOR EVERY USE

Potatoes and other starchy vegetables, are a source of carbohydrates for energy.

Green, leafy vegetables—lettuce, spinach, and others—yield iron, calcium, copper and other much-needed minerals.

Yellow vegetables, such as sweet potatoes, and carrots, offer carotene, from which the body can produce vitamin A.

Tomatoes and cabbage are rich in vitamin C.

The legume vegetables, beans and peas, yield such B-complex vitamins as thiamin, riboflavin, and nicotinic acid.

All vegetables are good sources of most vitamins, and they are all substantially rich in minerals.

Is Canning Harmful?

Canning is a process of preserving foods by heating them to a sterilization point and then sealing them in air-tight containers. It is a fairly simple process, and yet, in times past, its very simplicity brought it under suspicion. "If foods can be preserved that easily," people once said, "canning must harm them some way."

That doubt seemed to be confirmed by the occasional spoilage of cans or bottles of foods, and not until 1895, when H. L. Russell of the Wisconsin Agricultural Experiment Station first applied bacteriology to canning, did most people admit that canned foods might be perfectly wholesome.

Then, with the advent of the vitamin, suspicion arose again, and people began to wonder what effect heat had on the vitamin content of foods in the canning process. The first tests, made when the B-complex vitamins were still classed as a single vitamin B, indicated that canned vegetables lost much of that vitamin during the cooking process. The tests indicated that vitamin C, too, was largely lost, and cast a shade of doubt around the nutritive value of canned foods. But

soon came further studies which revealed that almost all of the vitamin content of food is retained in canning. The original mistake came about in this way:

The component parts of vitamin B, which was later broken down to include thiamin, riboflavin, and nicotinic acid as well as other minor vitamins, are soluble in water. That means that in the cooking process the vitamins are dissolved in the vegetable juices. Consequently, when analyses were made of the vegetables themselves, without the vegetable juices being studied, the cooked product was weak in the B-complex vitamins.

Later, when more complete tests were made, they revealed that thiamin, though it disintegrates when subjected to prolonged heat, can survive short cooking easily. Nicotinic acid, which is less important in most vegetables but available in fair amounts in peas and beans, is hardly affected at all by heat. But in both cases the vitamin dissolves in the juice, and appears more readily there than in the vegetable itself. The accessory food substance which was first called vitamin G, later classified as a B-complex vitamin and called B_2, and finally given the proper name of riboflavin, also dissolves in water and so appears in the juices of cooked vegetables more than in the solid food.

As for vitamin C, succeeding studies showed that cooking in the presence of air destroys that vitamin. So canners got around the problem by first sealing and then cooking tomatoes, cabbage and other vegetables rich in vitamin C.

Cautious Canning Retains Food Values

In the final balance, then, canned vegetables are substantially as efficient sources of vitamins as the original fresh foods; however two cautions must be remembered. The juice of cooked vegetables should always be served with the vegetables themselves or saved to be used in vegetable soups, to retain B-complex vitamins. Tomatoes and the other vitamin C vegetables should be served cold when possible, because reheating of canned foods of this class has a destructive effect on vitamin content. The addition of soda in cooking vegetables should be avoided, because vitamin C deteriorates more rapidly in an alkaline solution.

But fresh or canned, vegetables are tremendously important in the diet. They deserve a place alongside such stand-bys as milk, butter, cheese, fruits, eggs, and meats.

Menu Planning

The final word in menu planning, in light of these facts, is this:

Everyone should get at least a serving a day of leafy green or yellow vegetables, a daily helping of potatoes, and a serving of tomatoes, cabbage or other source of vitamin C.

Any well-balanced diet must recognize the importance of vegetables, for they have their place on every menu.

SOME OF OUR HEALTH ACHIEVEMENTS IN WISCONSIN

Wisconsin workers lose fewer days from their jobs as a result of sickness or accident.

This enviable health record, attained jointly through the worker's appreciation of his health, better living conditions, better nutrition, better medical care, and the assistance of industry, has made possible a saving of many millions of dollars.

Meat, A Body-Builder

By H. A. WAISMAN, R. W. BRAY, and IVA MORTIMER
University of Wisconsin, Madison

Meat analysis, meat production, and meat in the family food supply are all represented in this author group. Mr. Waisman handles the field of meat analysis, Mr. Bray is an authority on meat production problems, and Mrs. Mortimer is well acquainted with all the home economics angles in the use of meat in the diet.

Mr. Waisman, who has a Ph. D. degree and is a member of Sigma Xi and other national scientific groups, did both undergraduate and graduate work at the University of Wisconsin and is now a member of the biochemistry staff. He has worked extensively on the B-complex vitamins ever since science recognized that such vitamins could be isolated. His particular work has been the isolation and identification of B-complex vitamins, but in addition he has studied the quality of proteins, the effect of heat upon them, and the growth factors in chicks and rats. Mr. Waisman's present research is along a new line of biochemical research, a study of the relation of nutrition to bodily resistance, particularly in infantile paralysis. He has just completed publication, with C. A. Elvehjem, Ph. D., of a new textbook on meat, a summary of present nutritional knowledge of meat as a food.

The production, storage, and use of meat are the special interests of Mr. Bray. After completing his undergraduate work at the University of Wisconsin, he went to Kansas State Agricultural College for advanced study in meat animal production. Mr. Bray, who has an M. S., degree, is a member of Alpha Zeta, national agricultural honorary fraternity, Phi Kappa Phi, national scholastic honorary fraternity, and the American Society of Animal Production. His research includes studies of the effect of freezing on tenderness of meat and experiments on storage temperatures in meat. He teaches practical courses in meat production, carcass values, selection of cuts of meat, and the choice and use of meat in the diet.

Mrs. Mortimer, whose work covers the use of meat in the family menu, holds four university degrees. She has a B.A. and an M.A., as well as her B.S. and M.S. degrees in home economics with foods as a major. She teaches home economics courses in elementary foods, problems in the family food supply, and nutrition and dietetics, and is a member of Sigma Delta Epsilon, science honorary sorority, and Omicron Nu, home economics honorary sorority.

—CHARLES A. DAWSON, M. D., *Chairman, Committee on Public Policy*
State Medical Society of Wisconsin

AS RECENTLY as ten years ago, science was unable to prove that meat is a dietary necessity. As short a time ago as 1932 there was no evidence to deny that man could keep healthy on a plain vegetarian diet.

But things have happened swiftly in the last ten years. Nicotinic acid, which appears in quantity only in meat, has been revealed as the key to the cure for pellagra. Riboflavin, thiamin, and other B-complex vitamins have showed up richly in meat. Studies of protein have made it clear that meat is one of the nutritionally complete protein foods.

All in all, the last decade has made the vegetarian diet as ridiculous as the whiskey cure for snake bite. Good health demands a balanced diet, and a diet isn't balanced if it doesn't supply meat.

Meat is Important For Many Reasons

Why is meat so important? Principally, as mentioned before, because it supplies the B-complex vitamins, those accessory food substances which can hardly be obtained in proper variety and amounts from other types of food. As for vitamin A, liver is a good source, though other meat products are much weaker in this respect. Meat is important as a source of protein, energy and minerals.

But it might be wise to study systematically the vitamins and other elements in meat.

In vitamins, first on the list is vitamin A. An average, reasonably active man needs 5,000 International Units of this vitamin. Four ounces of liver ordinarily supply about 7,000 units. Other types of meat contain far less of this vitamin, but samples of liver may even run as high as 20,000 I.U. to a quarter

MEATS » » POULTRY » » FISH

They Supply the Body With:

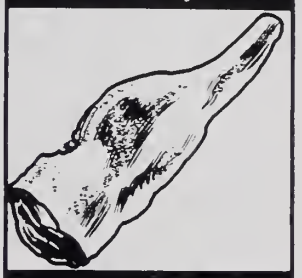
FUEL — Fats — Meat Fats and Lard

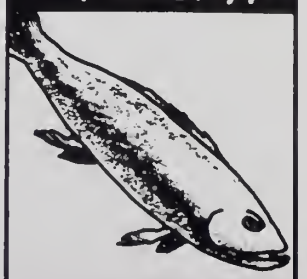
PROTECTIVE AND REGULATORY ELEMENTS

- Vitamins
  - A (Occurs in liver; protects the skin tissues against infections).
  - B-complex (These vitamins occur in abundance in all meats; essential to growth, digestion, and nervous stability).
    - Riboflavin
    - Thiamin
    - Nicotinic Acid
    - B_6 (Pyridoxine)
    - Pantothenic Acid
    - Biotin
    - Choline
  - K (Occurs in liver; protects against hemorrhages).
- Minerals
  - Calcium (Some in most meats; aids bones and teeth).
  - Phosphorus (Abundant in meats; important to growth).
  - Copper and Iron (Meat is a good source for the "blood" minerals).

BUILDING MATERIALS

- Minerals and Vitamins
- Proteins
  - All lean or mixed meats supply plenty of good, healthful, complete protein.
  - Adults need protein; children need it even more, for protein is the material of growth.





of a pound, so liver is an easily adequate source. Kidneys are of some importance here, too, for a quarter of a pound supplies 743 I.U. of the first vitamin.

Meats are inadequate in supplying vitamin D. Liver is the only meat form which contains vitamin D in any appreciable amount, and the vitamin content in this respect is variable and therefore not to be depended upon.

Vitamin C, the antiscorbutic vitamin, appears in meats in small amounts. It shows up in the adrenal glands and in some other tissues, though fruits and most vegetables are still the best practical sources.

In B-Complex Vitamins, Meat Leads

But in the B-complex vitamins, meat steps out in front.

Take thiamin for an example. Thiamin (vitamin B_1) is important for health of the nervous system, and has been publicized in recent months as the vitamin of whole grain foods. Four slices of whole wheat bread contain 160 I.U. of thiamin, but the same size helping of pork loin contains over 500 units. Heart meat is also high, with about 225 units in a quarter pound, and kidneys are equally good. Poultry and beef supply about 50 units in a quarter-pound helping, and so may help to supply the 600 I.U. which a healthy, moderately active man needs each day.

Nicotinic acid was mentioned earlier as the food element which cures pellagra. It appears in substantial amounts in all kinds of lean meats, but liver leads the parade. A 100 Gm. serving of beef liver contains 17.5 mg. of nicotinic acid.

Analyses of foods for the presence of nicotinic acid were originally carried on by experiments with dogs, for dogs must have the vitamin to prevent "blacktongue," an animal manifestation of the pellagra symptoms. Later chemical analysis was used, and still later microbiological tests were employed. Every study verified the conclusion that meat, supplying nicotinic acid as it does, is necessary to the prevention of pellagra.

Eat Liver For Vitamins

Riboflavin, which started out to be vitamin G, later was named vitamin B_2, and then ended up with its present chemical name, is a growth-promoting and nerve-stabilizing vitamin. Liver is one of the very best sources of that substance, and lean meats of all kinds do their part in supplying riboflavin. A quarter pound of liver contains up to 3,350 micrograms of riboflavin, where an adult needs only 2,700 micrograms.

Kidney follows along with 2,050 micrograms in 100 Gm. (less than a quarter pound), and heart is next with almost 900 micrograms. Even lamb, which trails with about 320, is still substantially a good source, and poultry, which offers only about 150, can even be used profitably for riboflavin needs in menu planning.

For vitamin B_6, beef liver, ham, and veal are all important sources. For pantothenic acid, liver, kidney, heart, beef round, and ham all rank high in content. Exact values for biotin, another B-complex vitamin, are not yet completed, but kidney and liver are excellent sources. Liver, kidney, and lean beef and pork all supply adequate amounts of choline, the final member of the B-complex, which is important to normal functioning of the liver and kidneys in the human body. Vitamin K, which helps promote blood clotting and prevents hemorrhages, is found abundantly in liver, though it does not appear to any considerable extent in any other meats. It was in liver, in fact, that the presence of vitamin K was first recognized.

Meat is important in many other respects, but in supplying the B-complex family of vitamins the necessity of serving meat in the daily diet makes itself apparent.

Here Are Some Vitamin Tables

Here is a set of tables worked out at the University of Wisconsin measuring the presence in meat of vitamin A and the three chief B-complex vitamins, thiamin, nicotinic acid and riboflavin. These tables summarize the story of meat and vitamins:

Vitamin A logically comes first.

VITAMIN A

From this food (100 Gm.)*	man gets this much (International Units)	Each day he needs: (International Units)
Liver	5,000–20,000	5,000
Kidneys	700–750	"
Beef	about 60	"

* 1 pound equals 445 Gm.

As mentioned before, in the B-complex vitamins meat stands out. Here are the B-complex measurement tables, worked out at the University of Wisconsin.

THIAMIN (B_1)

From this food (100 Gm.)	man gets this much (micrograms)	Each day he needs: (micrograms)
Pork loin	1,540	1,800
Veal liver	520	"
Leg of lamb	300	"
Veal hindquarter	350	"
Whole wheat (best non-meat source)	510	"
Cabhage (next best non-meat source)	84	"

RIBOFLAVIN

From this food (100 Gm.)	man gets this much (micrograms)	Each day he needs: (micrograms)
Veal liver	3,300	2,700
Beef liver	3,000	"
Beef kidney	2,050	"
Beef heart	880	"
Leg of lamb	320	"
Pork loin	240	"
Veal hindquarter	290	"
Cheddar cheese (highest ranking non-meat food)	600	"
Whole wheat (next in rank)	216	"

NICOTINIC ACID

From this food (100 Gm.)	man gets this much (micrograms)	Eacb day he needs: (micrograms)
Beef liver	17,500	18,000
Beef kidney	10,000	"
Beef heart	7,000	"
Veal quarter	8,000	"
Pork ham	8,000	"
Beef round	7,500	"
Peanuts (hest non-meat food source)	13,000	"
Whole wheat (next hest)	5,000	"

That roughly outlines the vitamin content of meats.

Now for a look at proteins. How important are they? The 1939 issue of the *United States Department of Agriculture Yearbook* puts it this way, "If there were any one 'secret of life,' protein might be considered to be at the heart of it, since protein is the essential stuff of which all living tissue is made."

Meat is one of the most prolific sources of protein, and at the same time it is one of the best sources. Those two statements sound like a duplication. In actual fact, they are not.

Proteins are made up of a number of essential amino acids. Some proteins supply all these necessary amino acids, while others offer only a few. Thus a food can supply a great amount of protein, but unless that protein is made up of the right constituents, the food is not a superior protein source.

Meat fills both needs. It supplies protein abundantly, and it supplies the right form.

THE PLACE OF MEAT IN THE DIET

In 1940, the last year for which figures are available, the average American ate:

55.2 pounds of beef,
7.3 pounds of veal,
6.6 pounds of lamb,
87.2 pounds of pork and lard, and
21.6 pounds of poultry.

That totals up to an annual figure of 177.9 pounds of meat for each individual.

Nutritionists calculate that the meat consumption for good health should be at least 170 pounds of beef, veal, poultry, and lamb, and at least 60 pounds of pork and pork products. That's a total meat quota of 230 pounds for each person each year.

In 1940 Americans were 52 pounds below this good-health quota.

Liver Offers Plenty of Good Protein

Of meats liver is the best protein source, and lean meats come next, followed by fowl and fish. General cuts of lamb and pork follow in line, then heart and kidneys, and then general cuts of beef.

All these are complete proteins. They are on a par with other complete proteins: cottage cheese, eggs, milk and cheese. Peas and beans come into the picture as important sources of supplementary protein, but they do not supply all the essential amino acids which the body calls for.

Energy, measured in heat calories, is the next need of the body. Fat meat, of course, is one of the most productive sources of energy. But ordinary cuts of meat, too, supply relatively high energy requirements.

Here are the approximate caloric values offered by a four-ounce helping of each of the following normal foods:

Pork	300 calories
Lean beef	170 calories
Fish	135 calories

Such energy foods as butter, of course, far surpass ordinary meat cuts in caloric value. But for the backbone of the body's energy

(Continued on page 558)

E. B. HART

Milk in National Health

An Interview with Prof. E. B. Hart

Chairman of the Section on Biochemistry, University of Wisconsin

Biochemistry—the chemistry of life—has had, over the last half century, a single goal: the enrichment of life for mankind.

Good health in animals has been studied, for from them man gets much of his food. New means have been arrived at for the preservation of food values. Scientific nutrition has permitted fullest use of all the vital health foods—vegetables, fruits, meats, and in particular dairy products—in the diet.

At the University of Wisconsin, as elsewhere in the country, the quest is unended and unending. Stephen Moulton Babcock and H. L. Russell devoted themselves to research and experimentation. E. B. Hart entered the field, and for four decades has done exceptional work in plant, animal and human nutrition. Hart heads a department which has numbered among its scientists such men as E. V. McCollum, Harry Steenbock, Conrad Elvehjem, and others, and which is giving inspiration to younger men building on the earlier foundations.

All these men seek one thing only; the chance to add to the world's effective knowledge. Their task does not, and cannot, end in the laboratory. They are doing their part to extend the practical application of their test-tube creations, just as Babcock and Russell and Steenbock speeded the way for man to apply the butterfat test, the tuberculin test for dairy animals, and the irradiation process for milk.

America owes them much for their efforts to make national good health a common thing, and not an unapproachable ideal.

—Karl H. Doege, M. D., *Medical Editor*
The Wisconsin Medical Journal

IF YOU had to choose a single food on which to live for the rest of your life, your wisest possible choice would be milk. That's the opinion of E. B. Hart of the University of Wisconsin biochemistry department. Milk is the only food which, without any help from other nutrients, could still give a healthful, balanced diet, he explains.

Of course the regular diet of milk, day after day, would have its disadvantages. It would get tiresome like any other one-food menu. But people have followed that ration for months at a time with satisfactory results on their health and well-being.

On the University of Wisconsin campus selected students have followed an all-milk diet for six-month periods, with only copper, manganese, and iron added. At the end of the experiment they have invariably been in as good or better physical condition than at the start. And while the record is being compiled, there's an authenticated case of a woman following an all-milk schedule for more than three years and retaining perfect health throughout the whole period.

Milk Adds to Any Menu

The significance of these tests is not the indication that milk can be an independently self-sufficient food, Hart points out. Their importance lies, instead, in the fact that they show what milk can add to any menu. Whatever the dietary deficiency, milk can usually contribute something to its correction.

It isn't right to say that milk has every needed food element. It is lacking in copper, iron, manganese, and vitamin D, and all of these food elements are especially needed by children and adolescents. But down the rest of the score card, through minerals and vitamins and proteins and fats and carbohydrates, milk qualifies.

Let's follow the score card through, starting with the vitamins.

"All the vitamins are present in milk in adequate quantities except vitamin D, and this can be added by several well-known practical methods," Hart observes. "The content of B-complex vitamins is fairly

abundant and also constant, due to the synthesis of these substances in the rumen of the cow."

In tabular form, here are the vitamins needed by man, together with the share of those vitamins supplied by milk.

The Vitamin	*Its Characteristics*	*How Milk Qualifies*
A	Oily, transparent, and fat-soluble. Helps maintain resistance to infection, promotes normal growth and normal teeth formation. Aids in maintaining highly accurate vision.	Milk is a good source, and particularly so if the cows have been fed a supply of vitamin A-producing feeds. Such feeds, in common use among Wisconsin dairymen, are legume silage, pasture and green leafy hay.
D	Necessary to proper use of calcium and phosphorus in the body. Consequently, it helps insure against poor bones and teeth.	Normally milk carries a negligible amount of this vitamin. Irradiated milk, however, is an excellent source.
C	Water-soluble. Important to the formation of supporting body tissues. Essential to proper maintenance of bones, teeth, and gum structure. Scurvy preventive.	Milk is an excellent source, a quart of milk offering up to a third of the normal day's needs.
Thiamin (B1)	The much-publicized "vitamin of morale." Essential to growth, carbohydrate utilization, and general health of the nervous system.	Milk is a superior auxiliary source. A quart of milk has from 0.3 to 0.5 mg. to the quart. Man needs 1.5 to 2.3 a day.
Riboflavin	Helps insure normal growth, skin health, and nerve structure. An enzyme in tissue respiration.	An adult needs 2 to 3 mg. daily. A quart of milk offers from 2 to 2.5.
Nicotinic acid (Niacin)	The antipellagra factor. A stable vitamin associated with skin health, digestion and nervous stability. Deficiency symptoms are nervous disturbances, diarrhea, skin disorders, and even pellagra.	Milk is less valuable than meats, for example, as a source of niacin. But a quart of milk can still supply up to a fifth of the daily needs.

The vitamin A in butter and cheese has a dramatic role in the present war, for RAF pilots in England follow a careful vitamin-A-rich diet to improve their eyesight for night flying.

Citrus fruits, tomatoes, and some other vegetables are important sources of vitamin C, but conditions seem to indicate that during the winter season a good many Americans who do not get these foods finish the year with cases of incipient scurvy. A quart of milk a day would go far toward correcting this situation.

Analyses for such vitamins as pantothenic acid, biotin, inositol, folic acid, and others have not yet been completed, nor has the function of these vitamins been completely clarified. However, in all major vitamin fields milk is important, and it seems likely that it will measure up equally well in these others.

Milk Rates High in Other Nutrients

Vitamins are of enormous importance to human health. But with the emphasis vitamins are getting in newspaper items, magazine articles, and food advertisements, the American public is beginning to believe they are the only food elements a person needs.

Nutritionists and physicians are not led astray. They know that there are other important food elements: minerals, sources of energy, and supplies of complete proteins. And nutritionists and physicians recognize that in these departments milk stands near first place.

Dairy Foods; the Best Source of Calcium

What are the minerals man must have? Well, let's see. Hart lists calcium and phosphorus for the teeth and bones, copper and iron for the blood stream, manganese, a reproduction factor, and all five for muscle-building and general body health.

Calcium and phosphorus, the bone-builders, appear abundantly in milk. Milk alone may not always supply enough phosphorus, but it always goes a long way toward filling the needs of that mineral. And for calcium, dairy products are a *must*. Calcium is not nearly so abundant and easily available in other major foods, as the traditionally poor teeth of the American people amply testify.

An adult needs about a gram of calcium daily, a pregnant or nursing woman requires up to two, and a child must have at least a gram or more. Milk supplies over a gram to

The Dairy Animal Yields Man's Richest and Most Complete Food.

the quart, and so the secret of good teeth and strong bones is inextricably tied up with dairy foods in the diet.

Copper and iron, important in blood-building, and manganese, which affects reproduction, do not appear in quantity in milk, primarily because milk is the natural food for the suckling young. The infant child or young animal is well-supplied with a large enough reserve of blood-building elements to last until he is old enough to turn to a natural copper or iron-supplying diet. But for the youngster, once weaned, until he has completed his years of growth and development, these minerals are vital. And though they are absent from milk, they appear in abundance in many green vegetables, and so should offer no danger of deficiency.

Iodine is an important mineral whose presence in the milk is dependent on the diet of the cow. It can be made to appear, if the cow is fed iodized salt or inorganic iodine. This process is practical, but unnecessary so long as iodized salt or sea food can fill the iodine needs easily.

How About Proteins?

Vitamins and minerals protect the body from infection and disease, at the same time supplying some materials for bone, tooth, and blood formation. Now another food constituent enters the picture: proteins, which provide material for the formation of strong muscular tissues.

Casein and lactalbumin are the significant dairy proteins, according to Hart. Milk includes other proteins, however.

Both casein and lactalbumin are physiologically complete; that is to say, they contain satisfactory proportions of all the amino acids which the body needs for balanced nutrition. In quality of protein, milk and eggs lead the entire field. And though meats offer a greater proportion of protein by weight than milk, the proteins of milk supply values which other foods cannot offer.

Milk Sugar Aids Metabolism

Not only does milk supply excellent proteins, but it also contains lactose, a sugar which has properties not found in other carbohydrates. Lactose encourages an acid reaction in the digestive tract, which diminishes putrefaction and the formation of toxic products which might be absorbed into the blood stream. It also assists in the utilization of calcium and phosphorus.

Whole milk is a fine source of fats, too. The fats of milk supply energy, and they also carry such fat soluble vitamins as A and K. The fats which appear in cream help in good body metabolism, as well.

"The fats of milk are of superior nutritive value," Hart points out. Not only do they supply vitamin A, but another element which makes whole milk a fine food for the young, the newly discovered fat growth factor. That element appears to be a saturated fatty acid which actually plays the part of a vitamin and is especially important to young animals. The factor has not been isolated nor identified, but it appears to exist only in animal fats. Thus reinforcement of vegetable oils with all the fat soluble vitamins now isolated still leaves those oils inferior as a food for the very young.

Milk fats are almost completely digested and used in the body, and though most fats can claim that same distinction, butterfat has some advantage. Physicians recognize this in their treatment of gallbladder patients, when they permit the free use of butter and cream, but prohibit other fats.

SCIENTIFIC PROTECTION

The quart of milk appears on the front porch almost magically every morning.

It's there when you get up.

It's ready for your early morning breakfast.

. . . But there's no magic involved in milk production and distribution. There's only a long and necessarily complicated process, the essence of which is speed, and at the same time complete protection for the consumer.

Energy Comes in the Milk Bottle

As a source of caloric energy, milk is very satisfactory. A quart of 4 per cent milk supplies a little less than 700 calories. The daily requirement for an adult varies from 2,500 to 6,000, depending on the season of the year and the energy expended in daily work. Thus milk can help in filling the energy requirements, and may also be employed to help regulate the caloric intake.

Incidentally, milk may be advantageously used in the reducing diet, supplemented by fruit juices, salads, and auxiliary sources of copper, iron, and manganese.

Pasteurization carried on by the newer processes has little effect on the nutritive value of milk. Some earlier methods partially destroyed the vitamin C and thiamin, but methods are being initiated to retain those vitamins. And even when there are minor losses of those two substances, milk remains an excellent protective and health-promoting food.

Some Figures on Food Needs

In final summary, Hart explains that milk in liberal quantities is a desirable addition to any daily food plan.

Here's the share of the nutrients an average man requires which can be supplied by a daily quart of milk:

Vitamin A	35 per cent
Vitamin D	10 per cent
Vitamin C	35 per cent
Thiamin	15 per cent
Nicotinic acid	20 per cent
Riboflavin	A full supply
Calcium	More than enough
Phosphorus	65 per cent
Protein	Almost half
Caloric energy	12 to 20 per cent

With that tabulation in mind, it takes no profound rationalization to explain why milk has always held a place as the first food in the human diet.

SOME OF OUR HEALTH ACHIEVEMENTS IN WISCONSIN

Hospitals are as available in Wisconsin as in New York.

Hospital facilities are within thirty miles of anyone in Wisconsin. Not only are hospitals as accessible as they are in the metropolitan city of New York, but there are relatively as many hospital beds in our state as there are in New York. In Wisconsin there are four and a fraction beds for every 1,000 persons, and in New York State there are four and a fraction beds for every 1,000 persons.

MEDICINE MARCHES ON—MORE SUFFERING SAVED

The average patient stay in hospitals in 1890 was 28 days.
Reduced in 1915 to 22 days.
NOW it is less than 9 days.

WAISMAN, BRAY, AND MORTIMER—MEAT, A BODY BUILDER

(Continued from page 551)

supply, the staple part of the diet, meats are unequalled.

Minerals Come in Meats

Meats are not exceptionally rich in calcium, milk and cheese being the best sources of that mineral. However, fish in particular and meats in general, supply a small amount of available calcium for better teeth and stronger bones.

For phosphorus in the diet, meats, fish, and poultry are at the head of the list, and for iron and copper they are again exceptionally high.

In the light of these figures, no room remains for dispute about the food value of meat. Where science could neither confirm nor deny, science now can assert that meat is one of the best foods that can go on the family dinner table.

The Rules For Meat Cookery

There's no question, then, that meat is healthful. Now how about tastiness? Well, a thick, juicy, carefully cooked steak is one of the finest dishes ever planned, and the less expensive meat cuts can be just as tasty. What's more, they are as nutritious.

Two simple cooking rules insure good vitamin retention and good flavor in almost any kind of meat. The first: Cook all meats at low temperatures. If they are roasted, the temperature should be 300 to 350 F. If they are cooked on top of the stove, they should be simmered. The reason for the low temperature is that meats shrink and lose more of their juices under high heat. That destroys or drains off much of the thiamin, takes away a lot of the flavor, usuallys cooks the meat unevenly, and reduces the total number of servings a piece of meat will yield.

The second rule: Use dry heat only on tender cuts, and cook with moisture on the less tender pieces. Dry heat will not make meat more tender, though if you have a cut which needs no tenderizing it can be tastily prepared by broiling or roasting in an uncovered pan. But to make a cut of meat more tender, braise, stew, or simmer, either adding liquid or cooking in a closed dish to obtain moist heat.

In point of food value loss, roasting is the most costly cooking process. There is a 20 to 40 per cent loss in thiamin and a somewhat smaller loss of riboflavin in roasting except under low temperatures, and even here there is a minor loss of thiamin. Thiamin is the only B-complex vitamin in great danger of destruction by high heats. Riboflavin is more stable, and nicotinic acid goes almost unaffected by high temperatures.

Meat is an easily digested food, and a good food for people of almost any age. There is no evidence that any of the meats produce difficulty of digestion, because experiments show that pork, beef, poultry, fish, veal, and lamb are all from 86 to 90 per cent digested.

Health is No Luxury in Wisconsin

It is worth mentioning, in light of these facts, that Wisconsin people can well afford to be among the most healthy people in America. All the vital foods mentioned in previous articles in this nutrition series—butter, cheese, and vegetables—are produced in significant amounts in Wisconsin. With meat, the story is the same.

Last year the farmers of Wisconsin marketed almost 500,000 beef cattle—250,000 tons of beef-on-the-hoof.

Packers took 2,306,881 head of hogs from Wisconsin farms to produce tasty, energy-giving, and vitamin-supplying pork products.

Over 1,000,000 head of veal—1,129,979, to be exact—were marketed last year.

From Wisconsin farms 327,479 sheep and lambs were sent to the packer to be converted into lamb chops and roasts for the tables of the midwest.

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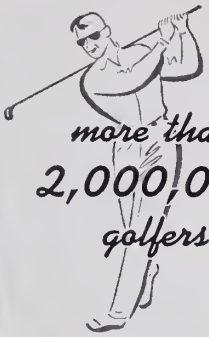

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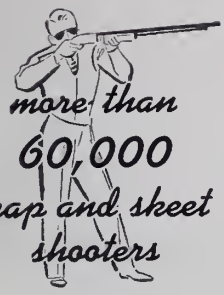

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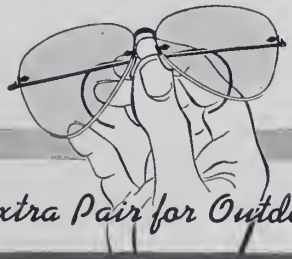

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[Entered as second class matter, June 30th, 1903, at the Post Office at Milwaukee, Wis., under Act of Congress March 3rd, 1879. Transferred to Madison, Aug. 1st, 1929.]
"Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized Aug. 7, 1918."

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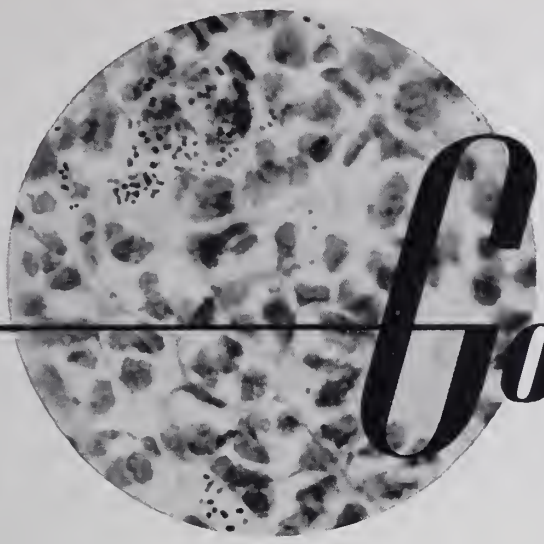

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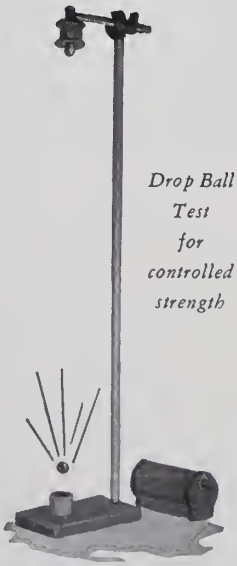

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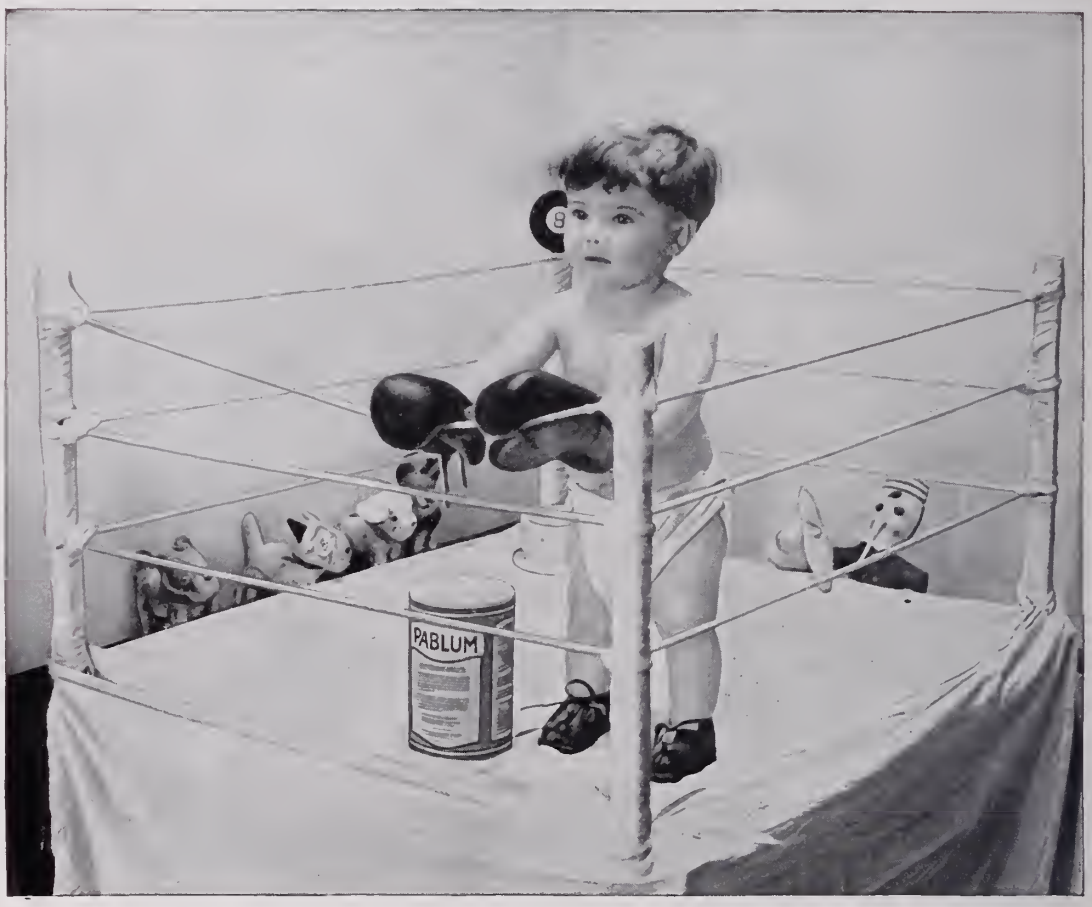

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THE WISCONSIN MEDICAL JOURNAL

VOLUME 41, NO. 7 Copyright, 1942, by The State Medical Society of Wisconsin JULY, 1942

Treatment of Carcinoma of the Prostate With Estrogens*

By WALTER M. KEARNS M. D.
Milwaukee

ADMINISTRATION of the old lady's hormone to the old man with prostatic carcinoma has produced strikingly beneficial effects. The immediate results parallel the benefits obtained with the administration of hormones in the well defined glandular deficiencies.

With the rapidly cumulating knowledge of male endocrinology during the last decade, facts concerning the hormonal control of the prostate gland have placed the hormonal treatment of carcinoma of the prostate gland on a sound theoretical basis.

Historical Material

The dependence of the prostate gland for its development upon the internal secretion of the testes has long been known. Hunter,[1] as early as 1786, called attention to the fact that the prostate in castrates is small and flabby. Later observers have consistently noted a definite atrophy of the prostate gland in castrates and eunuchoidal individuals. Moreover, we have observed the prompt retrogression of the normal prostate in 2 young men, 22 and 46 years of age, who were subjected to castration. A marked shrinkage took place after four to five weeks. In one instance,[2] the early atrophy was followed by regeneration of the gland after the autoplastic grafted testicular tissue had resumed function.

White,[3] in 1893, observing the retrogression of fibromas of the uterus after oophorectomy, anticipated that removal of the testicles might have a similar effect on the accessory male genital organ, the prostate gland, and recommended its use in prostatic hypertrophy. During the following ten years a large number of castrations were carried out, but the procedure promptly fell into disuse because of the mortality rate which it entailed, the lack of consistent results, the late ill effects of the operation, and the more satisfactory results anticipated with prostatectomy.[4, 5] The leading surgeons of the period reported an inexplicably high number of deaths with castration, and Cabot[5] found a mortality rate in 203 collected cases of 19.6 per cent, slightly higher than the mortality rate in a comparable series of prostatectomies.

In the light of recent developments it is reasonable to suppose that some of the better results of castration at that time occurred in patients with carcinoma.

During the last three years Huggins[6] and his coworkers have carried out ingenious experimental methods in dogs adding valuable information to the testis-prostate gland relationship. They[7, 8] were also the first to carry out castration and the administration of estrogens to patients with prostatic carcinoma. Their estimations[9] of the acid and alkaline phosphatase in the blood in patients with skeletal metastasis added corroboratory evidence to the salutary effect of castration and the administration of estrogens and to the deleterious effect of the administration of testosterone. They have stressed the greater importance of the acid phosphatase estimations as a criterion of the status of the skeletal metastases.

Choice of Method

In our hands the administration of testosterone to patients with benign prostatic hypertrophy, while it has increased the well-being, general muscular endurance, and bladder tone as evidenced by cystometric measurements and measurements of the residual urine, has not produced any discernible reduction in size of the hypertrophied gland. It was our early conviction, as stated at the St. Louis meeting of the American Medical Association in May, 1939,[10] that in some types of enlargement, especially the glandular types, the estrogens would prove more beneficial than androgens. This likelihood was brought into reality recently when one of our patients with a tentative diagnosis of prostatic enlargement with possible carcinoma was treated with testosterone

* Presented before the meeting of the Medical Society of Milwaukee County, April 10, 1942, and before the annual meeting of the Wisconsin Urological Society, Milwaukee, April 11, 1942.

with resultant aggravation of symptoms. Later carcinoma was demonstrated by prostatic resection and the patient was benefited by the administration of estrogens.

It is quite apparent that the presence of androgenic hormone in the body activates the growth of prostatic carcinoma and that diminution of the androgenic hormone brings about retrogression of the growth. The desired effect is accomplished by castration or by the administration of estrogens, the latter either neutralizing androgens, antagonizing them, or through effects on the anterior pituitary gland bringing about depression of androgenic activity in both the testes and adrenal.

In the choice of a method for the treatment of carcinoma it was our decision to choose the more conservative method, preferring the administration of estrogens instead of surgical castration with its attending confinement, economic loss, mortality rate, and likely unpleasant late effects.

No criticism of the method of castration is offered. Its beneficial effects have been demonstrated with certainty and in spite of the ill effects and its occasional inadequacy in relieving symptoms, it is undoubtedly justifiable in patients afflicted with carcinomatous disease. However, it is our contention that in making a choice between the two procedures the simple method of administering estrogens is preferred. It is given preference in spite of some drawbacks because of the excellent results obtainable with minimal inconvenience.

The ill effects of castration which caused White,[11] Thomson–Walker,[4] Cabot[5] and others at the beginning of the century to discard castration in the treatment of prostatic enlargement are still present. In our observations, over a period of four years, of 8 younger castrates, aged 22 to 53, it is noted that all suffer from varying degrees of mental depression, vasomotor disturbances and marked lassitude. Not one of them is able to do full-time work unless treated with testosterone. It is reasonable to assume that if castration in young men has such profound deleterious effects that old men will also be affected in like manner. The psychic and neurologic late effects of castration are apt to be minimized by present day enthusiasts for castration. Moreover, many patients object to loss of their testicles and will not consent to the removal. In order to convince them of the justification for castration, the surgeon is often forced to inform them of the presence of cancer, an admission most surgeons desire to withhold because of its demoralizing, hope-destroying effects. Moreover, in some instances ineffectiveness or inadequacy of castration as pointed out by Satterthwaite and his co-workers[12] has necessitated administration of estrogens to relieve symptoms. Likewise Huggins[13] has resorted to the use of estrogens as an adjunct to relieve hot flashes in certain castrated patients.

Removal of the testicles fails to remove all of the androgenic activity from the body since it is well known that the adrenal cortex performs an andro-mimetic function. This is evidenced by the presence of considerable amounts of androgenic hormones in the urine of castrates and in the demonstration of androgens in the adrenal cortex. In some animal species the sex behavior and even prostate gland development persist after castration. In the human the ill effects of castration are quite variable, possibly due to the variable in anterior pituitary gland activity and in the andro-mimetic function of the adrenal cortex. Immediately after castration production of gonad-stimulating hormone by the anterior pituitary gland is increased and with it a greater androgenic activity by the adrenal cortex. Huggins[13] and his co-workers have demonstrated both an increase in gonadotropins and androgens in the urine for some weeks following castration. Concomitantly with this there takes place an apparent temporary aggravation of the metastatic changes in the skeletal system. Some months following castration there is unquestionably a diminution of androgenic function but it is an uncontrolled activity.

On the other hand, the administration of estrogens effects depression of androgenic activity in a controlled reaction which is regulated by dosage. There is a direct and immediate action—the salutary effects being evident overnight. In those patients in whom potency has persisted prior to treatment

there is a development of impotence after the first few weeks of treatment. The loss of potency compares with the similar result following castration.

In almost every patient there develops some thickening of the mammary gland tissue. About 40 per cent of the patients develop varying degrees of annoyance from the mammary stimulation, but this is usually alleviated with reduction in dosage. The majority of the patients are unaware of any breast thickening until their attention is called to it. A slight thickening of the breast has been used as a criterion of adequate treatment, evidence that sufficient estrogens are being administered. The likelihood of the development of breast carcinoma is practically nil. There have been no proven occurrences in the male and thus far only questionable occurrences in the female following intensive estrogenic treatment. Certainly the carcinogenic effect of outlandishly large doses in castrated male rats should not deter one from using relatively conservative doses in the human. Even if a reasonably remote possibility of carcinogenesis existed the administration of estrogens in proven carcinoma would still be justifiable.

Thirty-Seven Patients

Beginning in the fall of 1940 the treatment of carcinoma of the prostate with estrogens was undertaken. The series now totals 37 patients. Seven of these patients have been observed by two of us in the wards of the Milwaukee County Hospital and the remaining 30 in private practice. The diagnosis was established through combined rectal palpation, perineal biopsy, prostatic resection, skeletal and chest roentgenograms, blood phosphatase estimations, and blood sedimentation rates. The ages of the patients ranged from 48 to 86 years with an average age of 66.6 years. Seven patients have died and 30 are still under observation.

The causes of death in 7 patients was as follows: 1 with pulmonary embolism after cystotomy, 1 with acute pyelonephritis and uremia two days after castration, 1 with pyelonephritis and generalized sepsis, 2 with bronchopneumonia, 1 with acute cholecystitis and cholemia, 1 with cerebral hemorrhage and pneumonia. Among these are 5 instances of intercurrent causes of death. In only 2 did the progress of the carcinoma appear to be the cause of death.

Dosage

At the beginning diethylstilbestrol was administered by mouth in 1 mg. doses three times daily for a period from two to three weeks. The dosage was then reduced to 2 mg. daily for two to four weeks and then reduced to 1 mg. daily indefinitely. The dosage in this manner is gradually reduced in an effort to maintain the patient's well-being with the smallest possible dosage.

There has been a remarkable clinical improvement with gain in weight, oftentimes immediate relief from pains throughout the body, improvement in blood counts, slowing of sedimentation rates, and an approach to normal in the phosphatase estimations. After four to five months there is improvement in the skeletal metastases as noted in roentgenograms. Surprising changes occur in the prostate itself as determined by the rectal finger. The gland not only shrinks in size but loses the dense nodularity, the fixation, and the indiscrete outline. After two months this change is unquestionable and one gets the impression of a much smaller sclerotic gland (table 1).

Herbst[14] has treated 7 patients with carcinoma of the prostate with estrogens. Estradiol dipropionate was administered to 3 and the remaining 4 were treated with diethylstilbestrol. All patients were improved in varying degrees; urination was freer, and shrinkage of the prostate as determined by the rectal finger was noted.

Table 1

Patients Treated With Both Castration (in Other Hands) and Estrogens

X-ray castration—unimproved followed by estrogen—unimproved	1
Estrogenic treatment—unimproved followed by surgical castration—unimproved	1
Estrogenic treatment—partial improvement followed by castration—partial improvement	3
Total	5

Hormone sensitive patients are improved by either method—those lacking hormone sensitivity are unimproved by either method.

Weller[15] likewise reports remarkably good results with the oral administration of diethylstilbestrol by mouth. He contributes most convincing evidence of the effect of the estrogen on the carcinomatous gland with stained sections of biopsy specimens taken before and after treatment. The widely proliferating glandular epithelium showed definite evidence of retrogression and replacement with fibrosis.

Gastric irritation has developed in 9 of our patients. This untoward reaction is lessened if the medication is taken with milk or small doses of sodium bicarbonate or if the dosage is reduced.

During the last eight months ethinyl estradiol has been administered by mouth. Since estradiol is a natural hormone as compared with stilbestrol, which is an entirely foreign substance to the body, being a drug with hormone-like action, we anticipated that the former would be better tolerated and perhaps less apt to produce untoward or unknown effects. Our patients receive 0.05 mg. thrice daily at the beginning. The dose after several weeks is reduced in a corresponding manner as with stilbestrol so that patients are given two 0.05 mg. doses per day during the ensuing several weeks when the amount is gradually reduced to 0.05 mg. once daily for an indefinite period. The potency of ethinyl estradiol is six to eight times as great as diethylstilbestrol. Similar beneficial and untoward effects as well have occurred with ethinyl estradiol, with the exception that there is definitely less breast stimulation with the true hormone and possibly less gastric irritation. Not only is the breast tenderness less apt to develop with estradiol, but changing from stilbestrol to estradiol brings about diminution of existing breast tenderness.

Herbst[13] states, "The breast changes are most interesting and variable with both substances. Unfortunately, the only patient in whom a large breast mass was formed, which

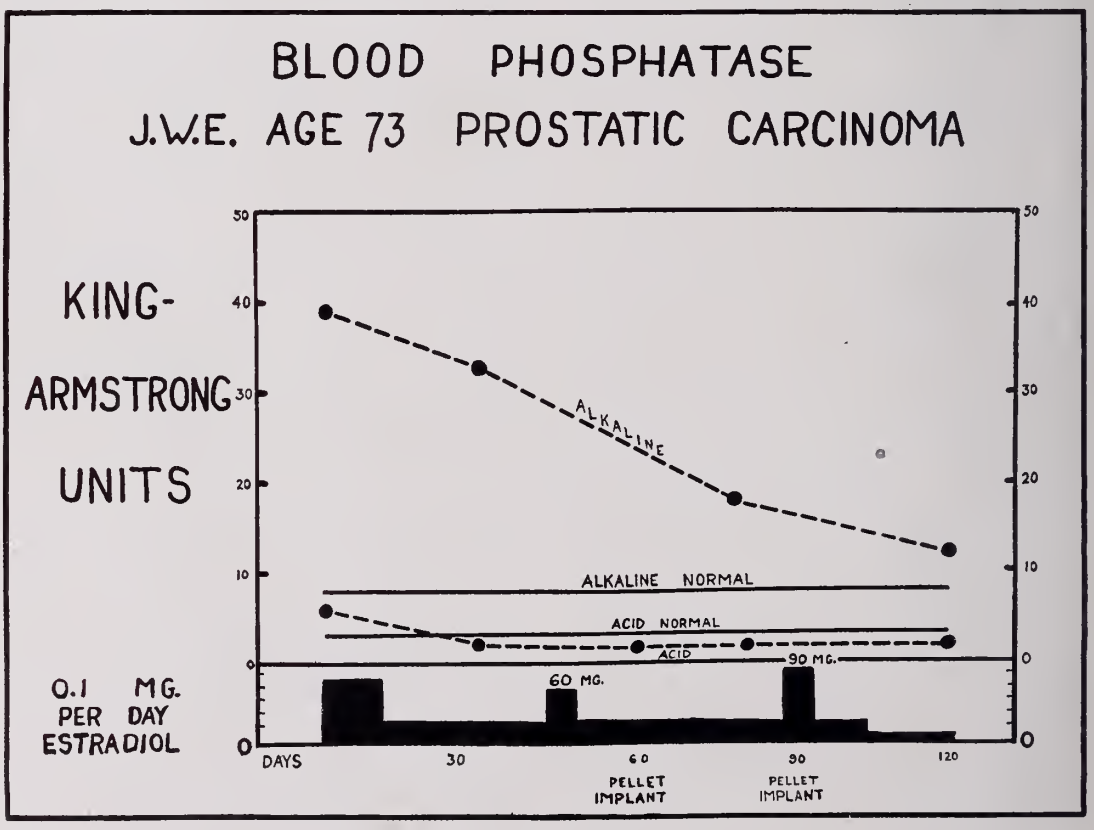

Fig. 1.

was about 4 cm. in diameter and 1 cm. thick, has not allowed us to remove it to date. This patient was one on diethylstilbestrol and had a very extensive involvement locally."

In 8 patients in whom there is even slight gastric irritation or in whom there is an objection to the oral administration we insert subcutaneously through a trocar two 10 mg. pellets of alpha-estradiol or two 15 mg. pellets of estradiol benzoate once monthly and maintain all of the salutary effects without gastric irritation. Pellet implantation may be administered alone or to augment oral administrations. Free alpha-estradiol has a potency of 12,000 R.U. per mg., while alpha-estradiol benzoate has a potency of 6,000 R.U. per mg., both as determined by the Allen–Doisy procedure.

Twelve of the patients received diethylstilbestrol only, 9 received ethinyl estradiol only, and 16 received both preparations.

Results

The 14 patients in the series on whom no surgery was carried out offer the best evidence of the efficacy of estrogens in the relief of symptoms of prostatic carcinoma. In 7 there were insignificant amounts of residual urine and no definite indications for surgical interference. In the remaining 7 of this group definite surgical indications were present including not only residual urine ranging from 30 cc. to 400 cc. but dysuria and frequency as well. The residual urine was reduced to negligible amounts and dysuria and nocturnal frequency were reduced or disappeared (table 2).

In 4 patients there was prompt disappearance of hematuria following treatment. In 1 of these there had been no previous surgery while in the other 3, prostatic resection had been carried out some months previously.

The estimation of the serum acid and alkaline phosphatase has been standardized

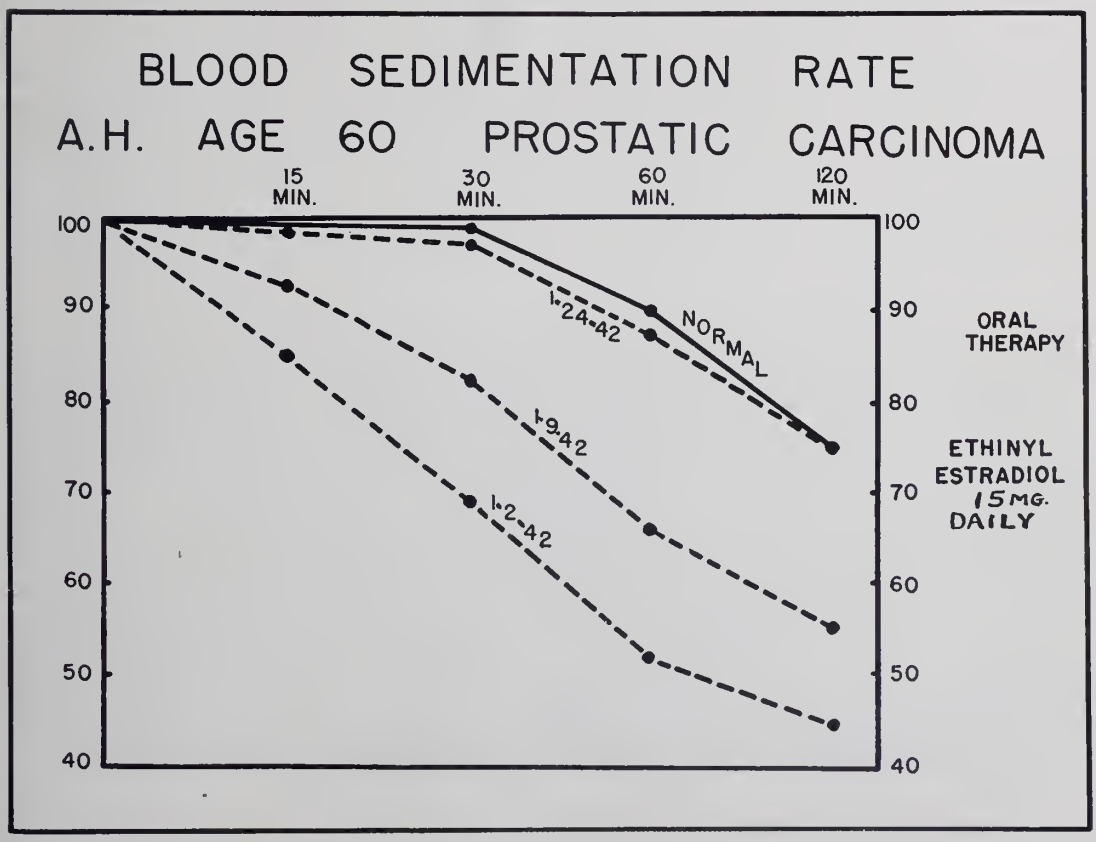

Fig. 2.

TABLE 2

ESTROGENS IN PROSTATIC CARCINOMA

Definite improvement	23
Partial improvement	11
Unimproved	3
Total	37

PREVIOUS HISTORY

Prostatic resection	14
Cystostomy	9
Resection and cystotomy (5)	
Surgical indications—no surgery	7
Surgical indications not present	7
Total	37

in several of the local hospitals according to the technic recommended by Huggins and Scott[9] and when all of the technical details have been followed meticulously, uniformity of results has been accomplished.

The phosphatase determinations give positive results in only about 50 per cent of the patients with bony metastasis and may be used as a measure of changes in the skeletal lesions, reliance being placed on the acid serum phosphatase determination as being specific for prostatic carcinomatous metastasis. When abnormal results are obtained, later repetitions of the tests serve as a good criterion of the effects of treatment. In our limited experience more striking deviations have been obtained with the alkaline phosphatase determinations than with the acid. The alkaline phosphatase curve loses its elevation quite promptly but has a lesser value because it lacks specificity. The alkaline phosphatase is apt to be elevated in Paget's disease, sarcoma and other bone lesions. The acid phosphatase is elevated only in prostatic carcinoma with metastasis (fig. 1).

Deviations from normal in the blood sedimentation rate occur in nearly 100 per cent of the patients. It has proven an excellent measuring stick of the clinical progress. The test is carried out at frequent intervals in the office and its simplicity recommends it as our greatest single laboratory aid. Remarkable improvements in the sedimentation rate almost immediately follow the institution of therapy. Rates which have been extremely rapid at the onset of treatment have approached the normal rate in the course of one month (fig. 2).

It is difficult to compare serial roentgenograms of bones because of differences in filming technic, the position of the patient, etc. Several patients did show definite improvement both as regards bone density and return to near normal bone contours. In my opinion, these changes are not demonstrable until the patient has been under treatment for at least four to five months (fig. 3).

Castration has not been carried out in a single instance up to the present. After comparing our results with those obtained by

Fig. 3. The roentgenogram at the left was taken at the beginning of treatment on October 16, 1941, showing marked involvement especially of both rami of the pubic bone. The roentgenogram on the right was made on April 6, 1942, showing definite improvement in bone structure and cortical outline. This patient received varying doses of diethylstilbestrol and ethinyl estradiol by mouth.

advocates of castration we have not been convinced of the necessity for operation. Three of the patients were castrated after a change in service at the Milwaukee County Hospital. Two of these patients died following operation and the third was unimproved. In no instance was there demonstrated any added improvement after castration as compared to the status with the previous administration of estrogens. Huggins refers to patients who respond to castration as being hormone sensitive. It is our early impression that the growth which is amenable to treatment at all will be as responsive to the hormonal administration as to castration.

Conclusions

1. Results of treatment of 37 patients with carcinoma of the prostate gland with estrogens are reported.
2. Beneficial effects are obtained in a large majority of patients treated with estradiol and stilbestrol.
3. Safety, economy, and comparable results give preference to the administration of estrogens over the method of castration.

Author's Note: My thanks are due Dr. Max Gilbert, Research Department, Schering Corporation, for the ethinyl estradiol tablets, and the pellets of alpha-estradiol and estradiol benzoate for implantation; to Dr. C. H. Mellish, Lakeside Laboratories, Milwaukee; to Dr. Murray Scott, Ayerst-McKenna, Rouses Point, New York, for experimental supplies of diethylstilbestrol; and to Dr. Harold W. Bruskewitz, intern, and Dr. Wilfred A. Flaherty, resident, Milwaukee County Hospital, Wauwatosa, for their assistance in this study.

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Plan now to attend the One Hundred First Anniversary Meeting of your State Medical Society in Milwaukee on Monday, Tuesday and Wednesday, September 14, 15 and 16. The preliminary program appears on page 605.

The Joint Responsibility of Obstetrics and Pediatrics in the Problems of the Newborn*

By A. H. PARMELEE, M. D.
Oak Park, Illinois

THE life of the human organism is divided into several epochs, which division is justified by certain characteristic anatomic and physiologic peculiarities. Puberty, the climacteric, and senescence are examples, in each of which there are physiologic, anatomic, and pathologic features which set it apart for special consideration. But the newborn period is the most dramatic of these epochs and by far the most hazardous. At no other period are such complicated and profound adjustments necessary as in this period of transition from intra-uterine to extra-uterine life. The great majority of newborns accomplish this transition so smoothly that we easily lose sight of the drama and the hazards involved. But when we study mortality statistics we see that in altogether too many instances something has seriously interfered with the success of this complicated transition. Deaths from all causes during the first month of life account for about half of the deaths in the whole first year, and three-fourths of these occur in the first week. These facts indicate clearly that prenatal and natal factors are the most important in the mortality of the newborn.

Cruickshank, according to Bonar,[1] made an analysis of the causes of neonatal death based on 800 autopsies. He found that in 67 per cent death was due to what he designated "birth effects" (asphyxia, atelectasis, injuries, and prematurity). In 30 per cent infective conditions were found to be the cause, and in the remaining 3 per cent there were gross congenital malformations. Even in the group classified as infective conditions, pneumonia was found in 83 per cent, many cases of which were due to the indirect effects of birth. Factors which predispose to atelectasis and asphyxial conditions, such as birth trauma, prematurity, and narcosis, produce favorable ground for the development of pneumonia.

The responsibility for the reduction of neonatal mortality would thus seem to rest largely upon the obstetrician.

How, then, does the pediatrician come into the picture? Pediatrics may be defined as a branch of medicine dealing with health and disease as affected or influenced by the various phenomena of growth. The growing organism, as exemplified in the human embryo, fetus, and newly born infant, is logically an important and most interesting field for pediatric study and investigation. Pediatrics is a relatively young specialty, but the results of investigations in this field have stimulated interest and added knowledge in many branches of medicine, not the least of which relates to the newborn. Knowledge of many physiologic peculiarities and diseases of the newborn has resulted from these studies, and the literature is filled with articles pertaining to the problems of fetal and neonatal life. Matters having to do with nutrition, icterus neonatorium, erythroblastosis foetalis, congenital anemia, epidemic diarrhea of the newborn, congenital syphilis, intracranial birth injuries, and hemorrhagic disease of the newborn have among others been the object of intensive investigation by pediatricians. The care of the newborn has been favorably influenced by this new knowledge. One of the most significant practical contributions to the reduction of neonatal mortality has been the great improvement in the care of the premature infant for which pediatrics has been largely responsible.

The nursery under the supervision of a pediatrician seemed to many of us a few years ago a long step toward solving the problems of the newborn. Where this idea

* Presented at the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

was put into effect there was definite improvement in the care of the newborn but not the drop in mortality that some expected. This optimism of some pediatricians could obviously not be shared by those who had studied the problem carefully. As is clearly indicated by the facts in this paper, only by a careful cooperative effort by obstetricians and pediatricians can we hope for significant improvement.

Events of recent years definitely indicate a growing realization that neonatal problems are as much a matter of concern to the obstetrician as to the pediatrician. In my opinion, the acknowledgement of this joint responsibility is the most encouraging advance yet made in this field.

Clearer understanding of many of the hazards of adjustment to extra-uterine existence has resulted from the combined studies and investigations of obstetricians, pediatricians, and physiologists. Let us briefly review some of the more significant of these adjustment difficulties and our present evaluation of them.

I. Asphyxia

In understanding and treating this common and troublesome condition much has been learned. To aid in our discussion we might profit by making first a classification of asphyxia similar to that proposed by Bonar.[2] Asphyxia is either of peripheral or of central origin.

A. Peripheral origin means some interference with the entrance of oxygen into the fetal circulation. This may occur either before or after birth.

1. *Before birth*—(a) due to premature separation of the placenta; (b) due to interference with the circulation of the umbilical cord.
2. *After birth*—(a) due to obstruction of the air passages from any cause; (b) due to atelectasis other than that due to obstruction of a bronchus (the atelectasis seen in the premature which is due to a soft chest wall and weak musculature, and that due to uninflatable immature lung lobules).

B. Central origin means interference with the function of the respiratory center. This may be the result of:

1. Gross injury to the brain.
2. Circulatory changes associated with the phenomenon of shock and general anoxemia.
3. The effect of toxins, anesthetics, analgesics and sedative drugs reaching the brain through the maternal circulation.

The majority of cases of serious asphyxia are due to interference with the function of the respiratory center. The factors involved are chiefly the oxygen and carbon dioxide content of the blood and the rate of cerebral blood flow. In the premature there is the additional factor of immaturity of the respiratory center. Under normal conditions, respiratory activity begins almost simultaneously with the birth of the infant. It is generally conceded that the initiation of respiration is due to stimulation of the respiratory center and that carbon dioxide is the chief stimulant material. But the factors which govern the action of the stimulus are still not quite clear. The work of Snyder and Rosenfeld[3] demonstrating fetal intra-uterine respiratory movements in experimental animals has been confirmed by some investigators and not by others. But there seems to be considerable proof that the mechanism of respiration is already in action before birth. This means that actually respiration is not initiated at birth but simply is stimulated to full function at that moment. It has been demonstrated further by several investigators that sedatives, narcotics, and anesthetics given to the mother are capable of depressing or even inhibiting these intra-uterine respiratory movements. The implications of this conception are important and will be referred to later.

The chief element in the chemical regulation of respiration, according to Schmidt,[4] is the concentration of the stimulant material within the cells of the respiratory center. This is dependent upon three factors: the concentration of the stimulant material in the arterial blood, the rate at which stimu-

lant material is produced within the cells of the center, and the rate of blood flow through the center which determines the extent to which stimulant material can accumulate there. It has been proved experimentally that the respiratory center is influenced by changes in its blood supply and that respiratory response to changes in systemic blood pressure depends chiefly upon changes in cerebral blood flow. Normally, an increase in cerebral blood flow depresses, and a decrease stimulates respiration. This suggests that products of metabolism of the cells of the center play a part in regulating its activity. But there is an abnormal condition of the center in which respiration is depressed by a decrease in its blood supply, and stimulated by an increase. This is spoken of as the "reversal." Apparently the ability of the respiratory center to respond to stimuli depends upon a supply of oxygen adequate to support the metabolic processes upon which the functional activity of the cells depends. According to Schmidt, any agent normally a stimulant to respiration may cause depression, if applied in the presence of oxygen-lack in the brain consequent upon subnormal cerebral blood flow.

All this means that the cells of the respiratory center do not respond normally to stimulation unless they are healthy, and their health depends largely upon an adequate supply of oxygen. Therefore, conditions favoring either local intracranial stasis or general anoxemia will decrease the excitability of the respiratory center and interfere with normal respiration.

An understanding of these facts makes it clear that not only gross injury to the brain by trauma, but any obstetrical procedure which depresses circulation will interfere with the function of the respiratory center. And this includes narcotic, analgesic, sedative, and anesthetic drugs and gases.

The responsibility of the obstetrician is to avoid in so far as possible any and all procedures that might depress the respiratory center of the fetus. This takes on new meaning if we accept the concept of intra-uterine fetal respiratory movements, for the duty of the physician is not to be directed toward initiating respiration after the birth of the infant, but much more toward avoiding the disruption of a mechanism that is already functioning before birth and will continue to function after birth if not injured.

The various factors in the causation of asphyxia in the order of their relative importance could be listed as follows:

A. Immaturity of the fetus.

B. Shock resulting from the trauma of labor.

1. Trauma occurring in a "normal" delivery.
2. Trauma occurring in a labor complicated by dystocia and operative delivery.

C. Anesthetics, analgesics, narcotics, and sedatives. These drugs and gases increase the incidence and degree of asphyxia in direct proportion to the amounts given.

II. Atelectasis

This term has been used rather loosely, and we would do well to inquire into its actual meaning.

The lungs of the normal full-term infant undergo gradual inflation during the first few days of life, and during that period a variable amount of initial or physiologic atelectasis is present. Various hindrances to respiration may result in an abnormal persistence of this condition. The persistence of large areas can be an important factor in causing death. What are the causes of pathologic atelectasis? Obstruction of a larger bronchus due to aspirated mucus or blood during birth is a frequent cause. Aspiration of regurgitated food, which is especially apt to occur in the premature, is a cause of atelectasis a little later in the newborn period. This is called resorption atelectasis for here areas of lung previously inflated become obstructed and resorption of the retained air results in collapse of the alveoli. In the premature also the peculiar tendency to edema and to hemorrhage plus the weakness of the muscles of respiration and the soft structure of the thorax result in large areas of obstructed alveolar tissues. Farber and Wilson,[5] who have studied atelec-

tasis very thoroughly, have summarized the problem as follows:

"The diagnosis of this condition as a complete and satisfactory cause of death, especially in premature infants, is widely accepted. It is obvious that when large areas of atelectasis are found in the lungs of a new-born infant who has died after exhibiting such evidences of imperfect respiratory function as constant or intermittent cyanosis, there must be a relation between the atelectasis and the anoxemia. The atelectasis may be accepted as the immediate cause of the anoxemia. It has seemed to us, however, that so long as the lung is anatomically perfectly developed, it is not logical to accept the existence of atelectasis as a satisfactory explanation of death; that, on the contrary, the atelectasis should be considered secondary to more fundamental causes and its pathogenesis more thoroughly considered."

In addition to the factors in the etiology of atelectasis already mentioned, imperfect functioning of the respiratory center should obviously be included.

III. Shock

There is a growing tendency to recognize that every newborn suffers from some degree of shock. The more immature the fetus the more profound the shock. This shock results from the birth process plus the conditions of his new environment, and the effects are seen in disturbances of the vasomotor apparatus, heat regulating mechanism, and water economy. Evidences of the effects of this birth shock can be demonstrated later in certain growth phenomena, such as neonatal lines in the tooth structure and at the epiphyses of the long bones, and also in the delayed skeletal development of the premature.

IV. Anoxemia

We are recognizing now that anoxemia has an effect upon the health and integrity of tissues in certain vital areas; the degree of its effect depends upon the severity of the anoxemia and the relative vulnerability of the tissues. Brain tissue is especially vulnerable. Recent investigations clearly indicate that damage to the brain from anoxemia may explain many of the transitory neurologic symptoms observed in the newborn, and probably some of the permanent brain injuries, the etiology of which has been a matter of dispute for so many years.

V. Prematurity

This phase of our problem is extremely important and has been attacked with most encouraging results. It is recognized that the state of maturity of the fetus at birth is one of the chief factors in determining its ability to make the adjustments required for extra-uterine life. The more nearly mature the fetus is the greater the chances of survival. The obstetrician recognizes this and makes an effort to prolong pregnancy or rather to delay the interruption of pregnancy when possible without unduly endangering the mother in order to have a more mature infant with greater viability. On the part of pediatrics too we are recognizing that "physiologically, chemically, and from an immunological standpoint these infants are immature and that a knowledge of these characteristics is essential in their proper care."[6]

VI. Maternal Health

The importance of the mother's health as a factor in neonatal morbidity and mortality is receiving more and more attention. Any disease of the mother, infectious or metabolic, acute or chronic, may affect the health of the fetus and add to the difficulties of the newborn period. Some of the diseases which we consider of particular importance are the toxemias of pregnancy, heart disease, nephritis, tuberculosis, malignancy, disease of the thyroid gland, diabetes, syphilis, and nutritional disturbances. In the last few years special attention has been paid to nutritional disturbances of both the quantitative and qualitative types. Specially important has been the discovery of the relationship of hemorrhagic disease of the newborn to deficiencies of vitamin K and perhaps also vitamin C. The subject of maternal health as related to the health of the newborn offers much material for our cooperative studies.

A study of the records of 9,365 consecutive live births at the Presbyterian Hospital, Chicago, revealed that 592 were premature, an incidence of 6.3 per cent. There were in this group 6,007 mothers who were considered healthy. Of these, 311 had premature

infants, an incidence of 5.2 per cent. While 3,358 mothers who had some medical complication had 281 premature infants (8.4 per cent). More striking, however, was the effect upon mortality. The gross fetal mortality of the infants born of healthy mothers was 1.8 per cent, while that of the infants born of mothers with some medical complication was 3.5 per cent.

Suggestions

Due to the cooperative efforts of the obstetrician and the pediatrician advances in our knowledge of the problems of the newborn have been encouraging. There remains much that can be done by a more general recognition of our joint responsibility. Some of the ways by which the problems of the newborn can be made easier and future neonatal mortality statistics improved through cooperative effort are suggested herewith.

1. Better teaching of newborn physiology and pathology to medical students, interns, residents, and nurses.

2. More and better autopsies on stillborns and on infants dying during the newborn period.

3. Proper hospital organization for the control of the technic of the maternity division including the maternity nursery.

4. A cooperative, self-perpetuating organization of the obstetric and pediatric interns, residents, and nurses in our larger hospitals to take care of neonatal emergencies: "a life saving team" for the delivery room and the nursery.

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PHYSICIANS' HOBBY SHOW

Through the efforts of Dr. C. J. Smiles, Ashland, a member of the Council on Scientific Work, a Physicians' Hobby Show has been arranged for the One Hundred First Anniversary Meeting of the Society.

Physicians throughout the state have reserved space for display of their hobbies. Noteworthy is the display to be presented by Dr. Paul F. Doege, Marshfield, consisting of a collection of firearms used during the last hundred years. Dr. R. G. Arveson, Frederic, will display a collection of bells assembled from all parts of the world; and Dr. Salvatore Megna, Milwaukee, will show an elaborate collection of glassware. Physicians interested in outdoor sports will enjoy the waterfowl photographs belonging to Dr. H. J. Lee of Oshkosh.

Exhibits to be shown are listed on page 603. Physicians wishing to exhibit hobbies are urged to contact Dr. Smiles so that space reservations may be made.

Comments on Treatment

Editor—A. J. QUICK, M. D., Marquette University, Milwaukee

On the Detection of Potential Pulmonary Embolism and its Prophylaxis

Clinical and laboratory investigators on the etiologic factors of pulmonary embolism have dealt primarily with the injury to the vessel wall, slowing of circulation and acidosis. Little work has been done with the intrinsic changes in the blood itself which accompany the process of thrombosis.

In studying the behavior of coagulated blood in a test tube, it was observed that the clot in certain patients retracted fast whereas in normal individuals retraction set in only after thirty minutes or more. Particularly interesting was the finding that in a patient with a nonfatal embolism, clot retraction was strikingly rapid.

Of the tests employed in the study of hemostasis, retraction time has received relatively little attention. It has been known for many years that clot retraction is absent or greatly delayed in thrombocytopenic purpura although the coagulation time is normal. It is possible that the hemorrhagic tendency in this disease is in some manner related to the abnormal behavior of the clot. One can speculate that perhaps in thrombosis, the opposite state of affairs holds—namely, a virtual hypercoagulability of the blood in vivo—with a normal coagulation time in vitro; and that such a condition might manifest itself by a shortening of the clot retraction time.

This has been borne out so far in 7 of 8 cases of pulmonary embolism. In these clot retraction, which normally is at least twenty minutes, was ten minutes or less. In all of these cases the sedimentation rate was also rapid, and a moderate to severe grade of anemia was present.

It was further found that clot retraction time was usually accelerated following a surgical operation, reaching its most rapid rate between the fifth and eighth day, and then gradually returning to normal.

In thrombophlebitis and phlebothrombosis a similar condition was found. The clot retraction time is shortened during the more acute phases, and as convalescence progresses the retraction time returns to the normal range.

The test therefore appears to be a sensitive means for detecting potential candidates of thrombosis and pulmonary embolism. With the test one can select the patients who should receive prophylactic treatment, that is, heparin therapy.

It has been found that heparin given intravenously greatly increases the clot retraction time. Small amounts (200 anticoagulant units or 100 mg.) greatly prolong clot retraction time without appreciably affecting the coagulation time. This action may persist for as long as twenty-four to thirty-six hours. Some individuals require larger amounts of heparin during the acute phase to produce this effect. This prolongation is also produced when heparin is added to blood in vitro in concentrations similar to that in the blood in vivo.

The test is relatively simple; only two dry serologic tubes and a clean dry syringe and needle are required. Four cubic centimeters of venous blood are withdrawn, and 2 cc. are placed in each tube. The coagulation time is then determined by measuring the time from withdrawal of blood to the point at which it ceases to flow when the tubes are inverted. The end point of coagulation becomes zero for the retraction time. The beginning of retraction is best observed by watching the loosening of the clot from the sides and bottom of the test tube.

John S. Hirschboeck, M. D.
William L. Coffey, M. D.

Much interest now centers in the prevention of postoperative thrombosis. In addition to heparin, dicoumarin, the sweet clover factor, is being actively studied in various clinics. A combination of dicoumarin with heparin therapy appears to be promising.

A. J. Q.

The Nation at War

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Says Public Must Aid Doctors in Meeting Nation's War Needs*

Unreasonable Demands on Physicians' Time and Preventable Disease Must Be Reduced to a Minimum, Paul V. McNutt Declares

PREVENTABLE illness and unreasonable demands on the time of physicians must be reduced to a minimum because of the urgent need for physicians for the armed forces, Paul V. McNutt, chairman of the War Manpower Commission, declares in a special statement for *The Journal of the American Medical Association* on "The Procurement of Physicians." The statement published in the June 27 issue, is as follows:

"On June 8 I described to the American Medical Association at its Atlantic City meeting the acute need for physicians for the military services. I pointed out how far the recruitment of physicians lagged behind expected quotas. In conclusion I stated bluntly the fact, which could not have been evaded by any analysis, that unless voluntary recruitment progressed more rapidly some more rigorous form of selective service must be resorted to.

"Those facts were necessary in order to permit the medical profession to diagnose its own case. And the case is urgent; physicians are members of what is probably the most indispensable of all professions. Despite the harshness of the facts and the bluntness with which I had to state them, I felt that the profession should be informed.

"In fairness to the recruitment record of many of our states, it seems in order at this time to give the profession some further idea of how its problem is distributed. The failure of a sufficient number of physicians to volunteer for military service is not spread thinly over the whole country. There is an acute lag in certain populous states. Other states have supplied nearly all that they should supply.

"We need more than twenty thousand additional physicians by the end of this year. But eight states—New York, Illinois, California, Pennsylvania, Massachusetts, New Jersey, Michigan and Ohio—should account for nearly sixteen thousand of that shortage.

"By contrast, sixteen states have fewer than a hundred physicians to go to reach the total number they should supply. In order not to deplete unduly available medical service in those areas, we are asking that the Medical Officers Recruiting Boards be withdrawn and that further enlistments from those areas be then discouraged except in the case of the men under 37 in the urban areas. Those states are Alabama, Arizona, Delaware, Idaho, Louisiana, Mississippi, Montana, Nevada, New Mexico, North Dakota, South Carolina, South Dakota, Utah, Vermont, Wyoming and Virginia.

"The acute problem for the next few months for those states is an equitable distribution of medical service within their borders. This will avoid the necessity for any consideration of plans to allocate doctors from other states to meet civilian needs.

"More than one hundred and thirty thousand physicians have returned their registration forms to the Roster for Scientific and Technical Personnel. Those forms are now being processed. When that work is com-

* Reprinted from *American Medical Association News,* June 25, 1942.

plete we shall be able to give the profession a more comprehensive report on the relation of available medical service to wartime needs.

"The seriousness of the deficit in the number of physicians available for armed forces should not be underestimated. The need must be met. It will be met by one method or another. Neither must we underestimate the serious drain this puts on available medical services in civilian communities. It will mean long hours and hard work—sacrifices which will multiply the deep debt that every community owes to its physicians.

"It cannot be met simply by multiplying the hours of the physicians who are left. There will be a real need to exercise every possible means for minimizing unnecessary medical services in order that the real needs may be met.

"It is my belief that the lag in recruitment has been due chiefly to the fact that the individual physician has not realized the genuine urgency of the need. Measures must be taken which will bring this home to every individual. This means that there will have to be some education of the general public. Preventable illness must be reduced to a minimum. Unreasonable demands on the physician's time must be reduced to a minimum. Thus only may available medical service adequately cover the needs."

An editorial in the same issue of *The Journal* says:

"Elsewhere in this issue appears a statement by Mr. Paul V. McNutt, chairman of the War Manpower Commission, under which the Procurement and Assignment Service for Physicians, Dentists and Veterinarians functions, relative to the urgent need for physicians for the armed forces at this time. Mr. McNutt recognizes the indispensable character of the physician for both military and civilian needs. He makes clear that eight states—New York, Illinois, California, Pennsylvania, Massachusetts, New Jersey, Michigan and Ohio—must supply most of the physicians needed for the armed forces at this time. Some of the states have already supplied so many physicians in proportion to their total medical population that recruitment in those states is to be discontinued now or in the near future.

"The medical profession cannot be accused of failure to play its part in any way in relationship to the war effort. Every one who is participating in the recruitment of physicians recognizes that there have been what are now called innumerable 'bottle necks' to be cleared away from time to time as the effort has progressed. More than one hundred and thirty thousand physicians have already returned the registration blanks sent out by the National Roster of Scientific and Technical Personnel. These replies have been coded, and punch cards have been made for them. Any physician who has failed to receive an enrolment form from the National Roster should write at once to the National Roster of Scientific and Technical Personnel, in care of War Manpower Commission, 916 G Street Northwest, Washington, D. C., requesting that an enrolment form be sent to him.

"Shortly there will be sent to every physician who indicated that service in the United States Army Medical Department would be his first choice or his second choice a letter as follows:

WAR MANPOWER COMMISSION
Procurement and Assignment Service
Washington
Procurement and Assignment Service for
Physicians, Dentists and Veterinarians

Dear Doctor

You have indicated your willingness to serve the Nation in this great emergency. The Procurement and Assignment Service of the War Manpower Commission now calls on you to enter the Service. Please apply at once for a commission. You have been selected from among the available physicians in your community by a process that is believed to be fair and impartial.

Complete and mail the enclosed post cards immediately. The Office of the Surgeon General or his representative will provide the necessary application forms and authorize the time and the place for your physical examination.

Do not take any definite action regarding your practice until you receive specific instructions from the War Department. Each physician who is commissioned is routinely allowed fourteen days to wind up his affairs after receipt of orders from the War Department.

The rapidity of recruitment now in effect makes this communication necessary and requires your full cooperation. Please do not delay.

Sincerely yours,

FRANK H. LAHEY, M. D.

Chairman, Directing Board
Procurement and Assignment Service

Enclosures
No. 92 6/22/42

"With this letter will be enclosed two postal cards, which will secure prompt action in relationship to the receipt of application forms and proper notification of the action taken in the responsible agencies in Washington.

"The needs of the armed forces for physicians are immediate; unquestionably those needs will be met. Physicians who are under 37 years of age and who have been classified by the Selective Service are susceptible to restudy of their situation and reclassification as these needs become more and more urgent. The medical schools, hospitals, public health departments, industrial concerns, in fact every agency utilizing the services of physicians, must cooperate by restudying the men classified as essential, so that only those who are actually essential in the most restricted sense of that word will be retained. All others must be made available as needed for the service of the nation in the armed forces.

"The Procurement and Assignment Service for Physicians, Dentists and Veterinarians was established to aid in the proper assignment of physicians in times like these to the tasks for which they are best fitted. Already this agency has been of immense value in the principles that have been adopted relative to the maintenance of medical education, hospital service and civilian health, as well as the study and evaluation of men for the Army and Navy medical departments. As the needs become more acute and the number of men available less, their task assumes increasing importance. The War Manpower Commission is now the agency under which the Procurement and Assignment Service functions. Through the activities of various subcommittees such problems as maintenance of essential staff members for hospitals, the determination of adequate medical service for the civilian population needs, of adequate personnel for urban, county, state and national health departments and the needs of industry are being given special consideration. The medical profession, as Mr. McNutt has repeatedly emphasized, has in these activities shown the way to scientific study and allocation of manpower in this emergency."

Dividends in Man Power*

A VERY considerable part of our fighting and productive force is the direct result of reduced mortality since the beginning of the century; and this in turn is to be credited to our organized public health effort and the remarkable advances of medical science in past decades. This effort has saved millions of babies, children, and young adults, so that now the numbers available for the fighting forces to defend the country, and for production in factory and field, are much larger than would have been possible under health conditions prevailing among us 40 years ago.

To obtain a numerical measure of what the improvement in our health conditions means in terms of man power, an estimate was made of the number of men of draft age present among us today, who owe their existence to the improvement in mortality since the beginning of the century. Taking into account on the one hand the survival rates which actually operated in the intervening years, and on the other the survival rates that prevailed at the beginning of the century (when men now 40 years old were born) it is found that 11 per cent of men between the ages 20 and 44 are among us simply because of improvement in mortality experienced since 1900.

* Reprinted from *Statistical Bulletin*, Metropolitan Life Insurance Company, February, 1942.

On the foregoing basis it is estimated that of the 9,000,000 new registrants of this month, 11 per cent, or 1,000,000 are included in our man power because of our advances in medicine and public health, as well as our rising standards of living. For the same reasons we now have another 1,800,000 men included among the 16,800,000 who had previously been registered. **Altogether, there are among us 2,800,000 additional men available for combat and production who would not have been here if our country had continued to the present with the mortality of 1900.** This is a number equal to the entire draft army of 1917–1918. It is more than twice the number of our men who actually fought in France in the last World War.

Even so, this estimate of lives saved is a minimum number. It does not take into account the fact that many men of draft age would not even have been born because their parents would have been the victims of the higher mortality as of 1900. The contribution to our man power on this score must also be sizable, for this item depends on the improvement of mortality from 1900 to 1921, the period covering essentially the years of birth of the men of draft ages at the present time.

The many efforts that have gone into the improvement of the health of our people have contributed materially to our striking power in this war. Not only have these efforts given us more man power, but they have also given us the health and stamina necessary for a successful outcome. The situation calls for the maintenance of our present standards of public health and medical care.

MISS MILDRED FEHLHAUER APPOINTED NURSE DEPUTY TO THE STATE CHIEF OF EMERGENCY MEDICAL SERVICE

In accordance with the recommendations made by the Office of Civilian Defense, Dr. R. E. Fitzgerald, state chief of Emergency Medical Service, has appointed Miss Mildred Fehlhauer as his nurse deputy. This appointment has been confirmed by Mr. R. S. Kingsley, chairman of the Wisconsin Council of Defense.

Miss Fehlhauer was selected by the Wisconsin Nursing Council for War Service to assist in the development and organization of nursing personnel necessary to the full operation of Emergency Medical Service, and she will assist county chiefs in the solution of nursing problems.

The Office of Civilian Defense has requested that each county chief of Emergency Medical Service appoint a nurse deputy and has urged consultation with the County Nursing Council for War Service in making the selection.

In the near future a special bulletin on nurse deputies will be issued to the county chiefs by the State Medical Society.

Duties of the county nurse deputies are:

1. To maintain an active file of available nurses, kept up to date by, at least, a monthly check-up. A copy of the complete file should be provided by the nurse deputy for the chief of Emergency Medical Service. Duplicate cards should be on file at registries, hospitals or other suitable places for use in different parts of the community so that on short notice nurses may be secured for emergency duty in hospitals and casualty stations. In a large city, it is desirable to subdivide the duplicate file according to the districts or precincts in which nurses reside or work. In smaller towns or in rural districts only one file will be required.

2. In collaboration with the American Red Cross and the local chief of Emergency Medical Service, to provide all nurses with a first-aid course and instruction on gas protection and the care of chemical casualties.

3. To arrange with local agencies employing public health nurses, for home visits to (a) patients slightly injured who have been allowed to return home without hospitalization; (b) convalescent patients discharged early from hospitals to make room for casualties; and to assist the local chief of Emergency Medical Service to arrange for centralized reporting of the need for this nursing care in homes.

4. To assist the local chapter of the American Red Cross and the local hospitals to carry through a full program of training of nurses' aides for wartime service in civilian hospitals and health departments as well as in the casualty stations and first-aid posts of the Emergency Medical Service.

THE WISCONSIN MEDICAL JOURNAL

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Annual Subscription ---------- Three Dollars-Fifty Cents Single Copies ---------- Fifty Cents

Advertising Representative: Cooperative Medical Advertising Bureau, 535 North Dearborn St., Chicago, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, Madison

Volume 41 — JULY, 1942 — Number 7

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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« « « EDITORIAL » » »

Working in the Present and Planning for the Future

CHARACTERISTIC of the medical profession is its concern that while working on matters of immediate importance the problems of the future be not ignored. Examples are everywhere apparent. Months ago the physician, through the American Medical Association, planned for the role to be played by the profession in case of war. Now, while working on the problems raised by the war, the physician plans for the future. As an example, the American Medical Association at its recent annual meeting instructed the Council on Medical Education and Hospitals to develop a program of refresher courses for physicians returning to civilian practice after the war, and recommended to the trustees conferences with proper governmental officials looking to the possibility of granting leaves with full pay to those physicians who might wish to take advantage of such an opportunity.

The medical profession in Wisconsin has been thorough in its planning. Months ago it organized a committee on the participation of the medical profession in the war effort. It planned for what seemed the inevitable trend of events. That it did so, and well, seems assured from the fact that a recent listing in *The Journal of the American Medical Association* of those states which are falling behind in the supply of physicians to the armed services did not include Wisconsin.

Nor has the work of that committee, representing the entire medical profession of Wisconsin, been confined to the single task of securing physicians for the armed forces. A much broader duty has been assigned to it.

As the qualified practitioner of the community enters service his removal always leaves a gap, and often one of serious public health consequence. Increasing opportunities and unprecedented demand for physicians in industrial or governmental employment further complicate the picture.

For many months the machinery of the State Medical Society has been in motion, preparing for this particular situation. A survey of the needs of the entire state has virtually been completed, and the changing problems of a nation on war footing have been carefully studied. The matter has been considered one of state concern, and to that end the cooperation of individual physicians throughout Wisconsin has been developed to such a degree that the committee is now prepared to operate an "exchange" service, one which is designed to serve the pressing needs of community and state.

The tremendous effort required in the undertakings of our war committee can never be fully evaluated, yet to its members the entire medical profession owes a vote of deep appreciation. Through the work of that committee the public and the profession alike are once more assured of the physician's full measure of devotion to his community's welfare.

. . . . THE PRESIDENT'S PAGE . . . .

Organized Medicine Points the Way

THE summer months are with us again, and with summer comes the annually recurring worry of the profession relative to the poliomyelitis situation. To be sure, we may have poliomyelitis at any time of the year, but during the warm weather of August we are likely to see it reach epidemic proportions. Worried parents in every part of the state will consult their family physician to learn from him the last word on the status of prevention and treatment. This will be true particularly this year since the so-called Kenny treatment has received so much publicity in the lay press as well as in the scientific journals. Under the circumstances it is unfortunate indeed that this form of treatment of the symptoms of infantile paralysis was not subjected to more thoroughgoing investigation and check by scientific medicine before so much general publicity was allowed to spread over the land.

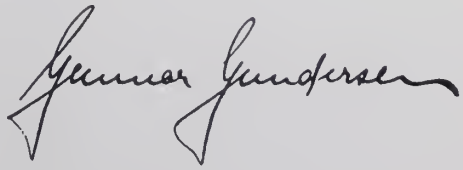
It reminds one of the unwarranted and unjustified claims of the "miracles" produced by the Warm Springs, Georgia, atmosphere of a decade or more ago when most, or all, sufferers insisted on seeking the healing surroundings of this overpublicized area as the answer to the infantile paralysis problem. The enthusiasm for convalescent serum in the early treatment of poliomyelitis is of so recent memory as not to require recounting.

The Section on Orthopedic Surgery of the American Medical Association, at the time, sponsored an investigation by competent medical men of the Warm Springs treatment with the result that the value of the treatment as offered at Warm Springs was judged in a scientific and deliberate manner.

At the ninety-third annual session of the American Medical Association last month in Atlantic City the same Section on Orthopedic Surgery again pointed the way when by official action it authorized the appointment of a committee of orthopedic specialists of unquestioned standing to investigate the "Kenny method of treatment."

At present the proponents of the method speak positively in terms of "mental alienation," "muscle incoordination," etc. If these terms have anatomic-physiologic significance, they most assuredly should be clarified.

Pending the conclusions and report of this special committee, those of us in the front line trenches, who will be the first to be bombarded by worried parents when the occasion arises, will do well to take a conservative attitude even though there will be unlimited pressure applied from many sources to force seasoned medical judgment to yield. Our motto should continue to be "Prove all things; hold fast that which is good."



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(ORGANIZED 1929)

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Preliminary Program Announced for Fourteenth Annual Convention of Auxiliary

Hotel Schroeder, Milwaukee, September 13, 14 and 15

Dear Auxiliary Member:

Convention time this year is September 13, 14, and 15 — only two months away! Your hostesses, members of the Woman's Auxiliary to the Medical Society of Milwaukee County, extend a cordial invitation to all wives of physicians, whether or not they are Auxiliary members, to attend the business sessions and social functions of the fourteenth annual meeting.

Incidentally, this year the State Medical Society is celebrating the first annual meeting of the second century of its existence. It is interesting to note in its program, which appears elsewhere in this issue, that "The Physician and the War" is a theme much emphasized, and the reports of our officers and chairmen will likewise emphasize the work which Auxiliary members are doing in the interests of Civilian Defense. I am sure this opportunity to discuss the efforts of the medical profession and its Auxiliary in wartime will be an inspiration to you as a physician's wife.

The complete program will be announced in the August and September issues of *The Journal*, but I should like to give you a few of the interesting high lights.

First, the headquarters will be at the Hotel Schroeder, and the meeting will open with the preconvention session of the Board of Directors on Sunday evening, September 13. Mrs. J. S. Supernaw of Madison, president, will preside. The second session of the Board will take place Tuesday noon after the last business session. Monday and Tuesday forenoons will be devoted to business sessions, with reports of state officers and chairmen and county presidents, and the election and installation of new officers. As you know, the incoming president is Mrs. Ernest S. Schmidt of Green Bay. The name of the guest speaker will be announced in a later issue of *The Journal.*

Milwaukee members are enthusiastic about the plans for the social entertainment of guests. This will include a luncheon followed by a style show on Monday. Hostesses will be members of the Walworth County Auxiliary. On Tuesday there will be a luncheon at the Cudworth Post of the American Legion, with members of the Kenosha Auxiliary as hostesses. This will be a round-table luncheon, the various tables being devoted to discussion of the activities of the Auxiliary. Officers and committee chairmen from the various counties will meet with the state officers and chairmen to discuss common problems. Plans for the entertainment on Monday evening are not yet complete, but you may be sure of an interesting and enjoyable program.

MRS. EBEN J. CAREY

MRS. ROBERT E. FITZGERALD

MRS. GEORGE H. EWELL

Wisconsin's Three National Officers

The Wisconsin Auxiliary is proud that again it has three national officers. At the recent meeting of the Woman's Auxiliary to the American Medical Association in Atlantic City, Mrs. Eben J. Carey of Wauwatosa was named president-elect. Mrs. Carey is well known in Auxiliary circles, having served nationally as treasurer, Hygeia chairman, and director, and also as state president.

Mrs. Robert E. Fitzgerald, a past-president of the national and state Auxiliaries, has held the offices of national chairman of press and publicity and national chairman of revisions. At the recent meeting she was named to succeed herself as parliamentarian.

Mrs. George H. Ewell, who previously served as state secretary, editor of the national *Bulletin*, and national press and publicity chairman, was selected to succeed herself as press and publicity chairman.

On Tuesday evening the members of the Auxiliary will join the physicians for the annual dinner in the Crystal Ballroom of the Hotel Schroeder. The speaker will be Col. Fred W. Rankin, president of the American Medical Association. Colonel Rankin, who is from Lexington, Kentucky, is at present stationed in the office of the Surgeon General in Washington.

An innovation in the State Society program this year is the Physicians' Hobby Show, which will be held at the Milwaukee Auditorium. Numerous physicians are scheduled to exhibit their hobbies. Further information concerning this feature of the program, which I am sure you will all wish to visit, appears on page 603.

Do mark your calendar now, reserving September 13, 14, and 15 for our fourteenth annual convention in Milwaukee. We shall look forward to seeing you.

Yours very sincerely,
MRS. RICHARD D. CHAMPNEY
Convention Chairman

County Auxiliary Proceedings

Fond du Lac

Mrs. Nora McGauley, Fond du Lac, was announced as president of the Woman's Auxiliary to the Fond du Lac County Medical Society at the final spring meeting held on May 28 at the Woman's Club, with Mrs. McGauley as hostess.

Other officers are the president-elect, Mrs. Ernest V. Smith, Jr.; treasurer, Mrs. Alvin C. Florin, and secretary, Mrs. Harve R. Sharpe. Delegates to the state convention to be held in Milwaukee in September are Mmes. McGauley, Smith, Jr., Henry E. Twohig, and Adolph M. Hutter.

As its project the Auxiliary voted to support the Memorial Fund of the Cancer Control Drive. The committee in charge is composed of Mmes. Charles W. Leonard, Patrick G. McCabe, and Harve R. Sharpe.

Kenosha

The Woman's Auxiliary to the Kenosha County Medical Society and the Druggists' Auxiliary met on June 2 at the Elks' Club, Kenosha, for a banquet on the terrace. After an address of welcome by the president of the Druggists' Auxiliary, Mrs. Leif H. Lokvam, president of the Kenosha Medical Auxiliary, presented awards to various members. Among

these were Mrs. Alexander Schlapik, chairman of the ways and means committee, and Mrs. Joseph P. Graves, who is entering her fifth year as treasurer of the Auxiliary. Following the banquet the two organizations adjourned to hold their separate business meetings.

La Crosse

The Woman's Auxiliary to the La Crosse County Medical Society held a meeting at Congregational Community Hall on May 20. Members of the Dental Auxiliary and Church Circle were guests for a beef-cutting demonstration. Mr. William Brueggemann gave the demonstration, and Miss Hantus Quarles, dietitian at La Crosse Lutheran Hospital, explained the nutritive value of the various cuts and proper methods of cooking.

During the business session the Auxiliary elected the following officers:

President—Mrs. Frederick H. Wolf, La Crosse

President-elect—Mrs. James C. Fox, La Crosse

Secretary-treasurer—Mrs. John J. Simones, La Crosse

Delegate—Mrs. Frederick A. Douglas, La Crosse

Outagamie

Twelve members of the Woman's Auxiliary to the Outagamie County Medical Society were present at a dinner meeting at the Candle Glow Tea Room on May 14. Mrs. Robert T. McCarty, president, presided.

As this was the last meeting of the season, a committee report was given on the volunteer aid that the members of the Auxiliary are giving to the Sisters of St. Elizabeth Hospital. At present members are awaiting materials for bandages for first-aid kits for Civilian Defense.

The Auxiliary decided to cancel the plans for the open meeting and tea, which has been a yearly project. Meetings will be discontinued until October.

Mrs. Edward J. Zeiss is the new president for the coming year.

Sheboygan

The Woman's Auxiliary to the Sheboygan County Medical Society met at the home of Mrs. Ira M. Bemis in Batavia on June 3, for a potluck luncheon which concluded this year's activities. Mrs. Joseph A. Russell of Random Lake was assisting hostess.

The retiring president, Mrs. Horace J. Hansen of Sheboygan Falls, conducted the short business meeting, after which the *Bulletin* of the Woman's Auxiliary to the American Medical Association was reviewed by Mrs. John J. Boersma, Sheboygan. Mrs. Gustav J. Hildebrand of Sheboygan has been named president-elect.

A bridge game followed the meeting, two guests, Mrs. E. P. Simms of Alamogordo, New Mexico, sister of Mrs. Edward Hougen of Sheboygan, and Mrs. Edward G. Schott of Sheboygan, winning high scores.

Waukesha

Dr. Owen C. Clark, Oconomowoc, was the speaker at the meeting of the Woman's Auxiliary to the Waukesha County Medical Society at the home of Dr. and Mrs. James C. Hassall, Oconomowoc, on June 3. Twenty-three members and four guests were present to hear a stimulating address on civilian morale. Suggestions for maintaining high morale were (1) proper nutrition, (2) recreation, and (3) diligent caution about repeating threats and rumors.

During the business meeting the president, Mrs. Traugott H. Nammacher, Oconomowoc, extended a welcome to three members who had been absent for some time—Mrs. E. Lee Lochen, Mrs. Leo W. Egloff, and Mrs. Walter S. Wing.

The minutes of the May meeting and the treasurer's report were read and approved.

Mrs. Joseph B. Noble, Waukesha, reporting for the History Committee, stated that fifteen photographs had been brought in and that the committee hopes to have a special display completed by fall.

Miss Harriet Baker, newly appointed county nurse, was introduced to the members and expressed appreciation for past services of the Auxiliary. She spoke of the need of a new projector in her work.

Mrs. Noble then read the report of the Nominating Committee, as follows: president, Mrs. E. Lee Lochen; president-elect, Mrs. James C. Hassall; vice-president, Mrs. K. W. Doege; recording secretary, Mrs. Floyd W. Aplin; corresponding secretary, Mrs. Herbert F. Sydow, and treasurer, Mrs. Donald C. Wilkinson.

Mrs. Herbert T. Barnes, Delafield, announced plans for the annual picnic to be held at Merrill Hills Country Club on July 8. Following adjournment of the meeting the members joined the members of the Medical Society for dinner as guests of Dr. and Mrs. Hassall, Dr. and Mrs. Clark, and Dr. and Mrs. Donald A. Morrison, all of Oconomowoc.

HOTEL RESERVATIONS FOR ANNUAL MEETING

Make your hotel reservations now for the One Hundred First Anniversary Meeting, September 13, 14 and 15. It is imperative this year, more than ever before, that hotel reservations be made in advance.

Society Proceedings

Ashland—Bayfield—Iron

The meeting of the Ashland–Bayfield–Iron County Medical Society on June 4 was devoted to a discussion of the Procurement and Assignment Service. The speakers were Dr. Robert E. Fitzgerald, Milwaukee, state chairman for the Procurement and Assignment Service, and Lt. Col. Amory A. Miller, Milwaukee, a member of the Medical Department Officer Recruiting Board.

Brown—Kewaunee—Door

A dinner and business meeting of the Brown–Kewaunee–Door County Medical Society was held in Sturgeon Bay at the Hotel Lucerne on June 11. Dr. E. J. O'Brien of Green Bay, secretary, reports that Dr. Daniel E. Dorchester of Sturgeon Bay presented a paper entitled "Methods of Treatment of Acromioclavicular Separation." At the business meeting members discussed the problems of mothers' pension and aid to dependent children, the compensation panel, and examinations at the Orthopedic School.

Dodge

When Dr. Alexander G. Hough, secretary of the Dodge County Medical Society, sent out notices for the May 28 meeting at the Country Club at Fox Lake he announced that the members would be guests of the president, Dr. Edward S. Elliott, Fox Lake.

The scientific program included a talk by Dr. Arnold S. Jackson of Madison on "The Treatment of Open Wounds by Application of Sulfanilamide." He also showed some movies taken on his travels. In addition, Mr. George B. Larson, assistant secretary of the State Medical Society, exhibited some displays prepared for the county fairs.

The outstanding feature of the social entertainment was a demonstration by Mr. John Snyder, Jr. of Cincinnati, the immediate past-president of the International Brotherhood of Magicians.

Eau Claire—Dunn—Pepin

The regular monthly meeting of the Eau Claire–Dunn–Pepin County Medical Society was held on May 25 at the 202 Club, Eau Claire, commencing with a seven o'clock dinner. Forty-four members were present.

Dr. Eben J. Carey, dean of the Marquette University School of Medicine, addressed the society. Talks were also given by Dr. Gunnar Gundersen, president of the State Medical Society, and Dr. Raymond G. Arveson of Frederic, councilor of the Tenth District.

Fond du Lac

Dr. Karver L. Puestow, associate professor of medicine at the University of Wisconsin Medical School, was the guest speaker at the dinner meeting of the Fond du Lac County Medical Society on May 28 at the Hotel Retlaw, Fond du Lac. His subject was "Gastroscopy." Fourteen members were present.

Green Lake—Waushara

Dr. Merritt L. Jones of Wausau spoke of "Interesting Cases" at a meeting of the Green Lake–Waushara County Medical Society held at the Berlin Memorial Hospital, Berlin, on May 28. Twelve members were present.

Iowa

A joint meeting of the Iowa County Medical Society and the Mineral Point Kiwanis Club was held on the evening of June 1 at the Royal Hotel, Mineral Point. Following a 6:15 dinner Mr. Charles H. Crownhart, secretary of the State Medical Society, spoke on "The War and the Medical Profession."

Jefferson

"The Corrigan Pulse" was the subject of a paper given before members of the Jefferson County Medical Society on May 21 by Percy F. Swindle, Ph. D., professor and director of the Department of Physiology, Marquette University.

Eighteen members attended the meeting, which was held at 6:30 at Shorecrest, south of Jefferson.

Manitowoc

The meeting of the Manitowoc County Medical Society on June 6 opened with a luncheon at the Hotel Manitowoc, Manitowoc. Following a business meeting, Dr. Maurice J. Reuter, Milwaukee dermatologist, conducted a clinic at which approximately twenty-five clinical cases were presented. After the clinic, he gave a talk on "Contact Dermatitis and Eczema," illustrated with Kodachrome slides.

Milwaukee

A special meeting of the Medical Society of Milwaukee County was held at the Marquette University School of Medicine on June 17. The subject under discussion was the Procurement and Assignment Service, the guest speaker being Dr. Harold S. Diehl, dean of the Medical School of the University of Minnesota.

Pierce—St. Croix

When the Pierce–St. Croix Medical Society held its monthly meeting at the Hudson Hotel, Hudson, on May 21 Dr. Joshua H. Armstrong of New Richmond spoke on the subject of "Endometriosis," with a discussion of three recent cases. Dr. Charles A. Dawson of River Falls gave a case report and discussion of the "Nonoperative Treatment of Ruptured Appendix with General Peritonitis."

Polk

Izaak Walton Camp on Yellow Lake, Webster, was the setting of a dinner meeting of the Polk County Medical Society on May 21. The fourteen members attending were guests of Dr. David A. Maas, Webster. After the dinner the following program was presented:

"Vertigo," Thomas J. Doyle, M. D., Superior

"Abdominal Conditions of Children Excluding Appendicitis," Henry A. Sincock, M. D., Superior

"Uterine Hemorrhage During Pregnancy," James W. McGill, M. D., Superior

"Emergency Medical Defense," Victor I. Ekblad, M. D., Superior

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Members of the Polk County Medical Society held a dinner meeting at the Clayton Hotel, Clayton, on June 18. Thirteen members and one guest, Dr. Lorne A. Campbell, Jr., were present.

The guest speaker was Dr. Otto W. Yoerg of Minneapolis, whose subject was "Fractures of the Os Calcis."

Price—Taylor

A luncheon meeting of the Price–Taylor County Medical Society was held on June 4 in Park Falls. Dr. John L. Rens of Phillips, secretary, reports that an election of officers was held, all those in office being retained for the following year.

Racine

A special meeting of the Racine County Medical Society was held at Sunny Rest Sanatorium on June 17. The following scientific program was presented:

"Artificial Pneumothorax at Sunny Rest," Carl O. Schaefer, M. D., Racine

"Thoracoplasty Case Reports," George N. Gillett, M. D., Racine

"Fungus and Fungoid Diseases of the Lung," William H. Oatway, Jr., M. D., Madison

Rock

"Ladies' Night" was observed by the Rock County Medical Society at its meeting on May 26 at the Hotel Hilton, Beloit. Seventy persons attended the 6:30 dinner and enjoyed colored motion and still pictures on "Wild Fowl and Bird Migration," which were shown by Dr. Howard J. Lee, Oshkosh, and Dr. Ralph V. Landis, Appleton. Mr. Charles H. Crownhart, secretary of the State Medical Society, discussed "The War in Relation to Medicine in Wisconsin." Dr. Cecil R. Gilbertsen, Janesville, and Dr. H. W. Bane, Beloit, were program chairmen.

Trempealeau—Jackson—Buffalo

The monthly meeting of the Trempealeau–Jackson–Buffalo County Medical Society was held on May 21 at Black River Falls. Dr. Alf H. Gundersen of La Crosse discussed "Infections of the Urinary Tract and the Newest Treatment of Cancer of the Prostate with Special Reference to Castration and the Use of Stilbestrol." Twelve members were present.

At the June 18 meeting of the Trempealeau–Jackson–Buffalo Society at the Whitehall Country Club, Whitehall, a new president-elect was selected, Dr. Bernard C. Dockendorff having joined the armed forces. The unanimous choice of the eleven members present was Dr. Max O. Bachhuber of Alma.

Waukesha

Dr. Owen C. Clark of Oconomowoc, president of the Waukesha County Medical Society, has submitted a report concerning the activities of the Waukesha County Medical Society for the first six months of 1942. The vice-president of the society is Dr. Paul E. Campbell of Waukesha, and the secretary, Dr. J. Francis Wilkinson of Oconomowoc.

The meeting on January 7 was held at the Avalon Hotel, Waukesha, with Mr. James O. Kelley, executive secretary of the Medical Society of Milwaukee County, as the guest speaker. His subject was "Emergency Medical Service in the Civilian Defense Program." Mr. Vernon Gaspar, county defense chairman, discussed county organization for defense.

A symposium on respiratory infections was presented on February 4, with the following participating:

"Respiratory Infections in the Child," Peter B. Theobald, M. D., Oconomowoc

"Respiratory Infections in the Adult," Campbell C. Edmondson, M. D., Waukesha

"Complications of Respiratory Infections," Frederick W. Madison, M. D., Milwaukee.

At the March 4 meeting Dr. John D. Wilkinson, Oconomowoc, gave an obstetrical case report, and Dr. John D. Owen, Milwaukee, discussed "Common Obstetrical Problems."

The guest speaker at the meeting at the Majestic Hotel, Oconomowoc, on April 1, was Dr. Maurice A. Hardgrove, Milwaukee. His subject was "Recent Advances in the Use of Human Serum and Plasma." Also on the program was Dr. E. G. Collins, Dousman, who discussed "Adrenal Cortex in Surgical Shock."

The meeting on May 6 was in charge of the staff at Wisconsin State Sanatorium, Statesan, and various speakers gave exceedingly interesting papers on the symptoms of early tuberculosis and modern diagnostic procedures. Following the scientific program the physicians and their wives were guests of Dr. and Mrs. Richard H. Schmidt of Statesan.

Members of the Waukesha County Medical Society and their wives were guests of Rogers Memorial Sanitarium, Oconomowoc, on June 3. Dr. Casimir F. Park, Milwaukee, spoke on "Diagnosis of Syphilis," and showed motion pictures. Dr. Donald A. Morrison, Oconomowoc, discussed "Psychologic Aspects of Medical Disorders."

Winnebago

Members of the Winnebago County Medical Society were guests of Miss Agnes Mattson, superintendent of Sunny View Sanatorium, Winnebago, for their monthly meeting on June 4.

Following a 6:30 dinner Dr. John D. Steele, thoracic surgeon at Muirdale Sanatorium, Milwaukee, spoke on "Indications for Bronchoscopy." Thirty-four members were present.

Second District

Members of the Medical Societies of Racine and Walworth Counties were entertained on May 27 by the Kenosha County Medical Society at the Kenosha Country Club. A varied program for the entire day had been arranged, and 140 physicians and their wives were present.

The morning session began at ten o'clock with Dr. Frederick H. Falls, Chicago, giving a paper on "Cesarean Section." Dr. James J. Callahan, also of Chicago, spoke on "Fractures of the Elbow." Lt. Col. Amory A. Miller, a member of the Medical Department Officer Recruiting Board in Milwaukee, discussed "The Procurement and Assignment Service."

Following a one o'clock luncheon the physicians played golf and the Auxiliary members played bridge. Prizes for each were awarded. A dinner for the physicians and their wives was given by Mr. R. J. Coleman, president of the United States Standard Products Company. After-dinner speakers included Dr. Gunnar Gundersen, La Crosse, president of the State Medical Society, and Dr. John S. Coulter, Chicago, regional medical officer of the Sixth Civilian Defense Area. Their general subject was "The Doctor and Hospital in Civilian Defense."

Fourth District

The Fourth Councilor District, comprising the counties of Crawford, Grant, Iowa, and Lafayette had a meeting at the Municipal Building, Lancaster, on May 21. The members of the Grant County Medical Society were hosts. Commencing at 2:30, the following program was presented:

"Problems of Organized Medicine in the Present Emergency," Gunnar Gundersen, M. D., La Crosse, president of the State Medical Society

"Vitamins and Nutrition," Edgar S. Gordon, M. D., University of Wisconsin, Madison

"The Use of Laboratory Procedures in Rural Practice," John A. Schindler, M. D., Monroe Clinic, Monroe

"The War and the Medical Profession," Mr. Charles H. Crownhart, Madison, secretary of the State Medical Society

"Procurement and Assignment Service," Lt. Col. Amory A. Miller and Capt. Norman L. Sheehe, Milwaukee, members of Medical Department Officer Recruiting Board for the State of Wisconsin

Following a dinner at the Wright Hotel in Lancaster, the thirty members heard Ralph E. Mutchler, D. D. S., of Milwaukee, state health supervisor of the National Youth Administration, discuss "The Health Program of the N. Y. A." They were also entertained by Dr. Emmett T. Ackerman, a member of the Houdini Club, with a program of magic.

Fifth District

The annual meeting of the Fifth Councilor District (Calumet, Manitowoc, Sheboygan, Washington, and Ozaukee Counties) was held on May 28 in West Bend. The scientific program was as follows:

"Management of Diabetes and Peripheral Vascular Diseases," Chester Coggeshall, M. D., Chicago

"Geriatrics," Ralph E. Dolkart, M. D., Chicago

"Menopause After Fifty," Ronald R. Greene, M. D., Chicago

"Refrigeration Anesthesia," Harry E. Mock, M. D., Chicago

Dr. R. E. Fitzgerald of Milwaukee, state chairman of the Procurement and Assignment Service, was also present. Dr. Kilian T. Bauer of West Bend showed his beautiful films of Hawaii.

The preliminary program for the One Hundred First Anniversary Meeting of your Society appears on page 605. The Council on Scientific Work has arranged an outstanding program devoted to most recent advances in the medical field so that members will be better prepared to care for both the civilian population and the armed forces.

News Items and Personals

Dr. Clair O. Vingom was re-elected chief of staff and *Dr. George G. Stebbins* was re-elected secretary–treasurer of the medical staff of the Madison General Hospital, Madison, on May 27. Others elected were:

Dr. Arthur C. Stehr, Madison, general practice chief
Dr. Arthur G. Sullivan, Madison, surgical chief
Dr. Hugh P. Greeley, Madison, internal medicine chief
Dr. Thomas A. Leonard, Madison, obstetrical and gynecologic chief

Diseases of the thyroid gland were discussed by *Dr. Edgar S. Gordon*, University of Wisconsin Medical School.

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Dr. John G. Meachem, Racine, known as the dean of Wisconsin physicians and a life member of the State Medical Society of Wisconsin, recently celebrated his ninety-sixth birth anniversary. He was graduated from Rush Medical College in 1865, and practiced in Racine until his retirement. *Dr. Meachem* recently donated a chapel and library to St. Luke's Hospital, Racine, commemorating the three generations of physicians from his family, and in memory of his wife.

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"Members of the medical profession in every county and state spend many hours daily and weekly in voluntary war work for the nation," said *Dr. S. E. Gavin* of Fond du Lac, chairman of the State Medical Society Council, when he addressed the Rotary Club, Fond du Lac, on May 25. Speaking on "The Medical Profession in the War," *Dr. Gavin* briefly outlined some of the voluntary war services of physicians.

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Dr. Oscar Lotz, part-time executive secretary of the Wisconsin Anti-Tuberculosis Association since 1939, has been appointed full-time secretary by the executive committee of that Association, it was announced on June 3. A member of the W. A. T. A. medical staff since 1915, *Dr. Lotz* has given up his private practice to devote all his time to this work. He succeeds the late *Dr. Hoyt E. Dearholt*, executive secretary of the Association since its establishment in 1908, who died in 1939.

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Dr. Mabel G. Masten, Madison, has been elected a member of the American Psychiatric Association.

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The importance of a just peace was emphasized by *Dr. Karl T. Kassowitz*, associate clinical professor of pediatrics at Marquette University School of Medicine, when he spoke before the Waukesha Rotary Club on May 25.

Dr. Ralph M. Waters of Madison, professor of anesthesiology at the University of Wisconsin Medical School, spoke at a meeting of the University of Wisconsin School of Nursing alumnae on May 30. His subject was "Pertinent Points for Nurses."

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"Mental depression by slowing down the patient may protect him against heart failure," declared *Dr. Lloyd F. Ziegler*, medical director of Milwaukee Sanitarium, Wauwatosa, speaking before the American Psychiatric Association. The meeting was held in Boston from May 18 to 22.

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Over 100 Wisconsin sanatoria personnel met at Statesan on June 20. *Dr. Gustav E. Eck*, Lake Mills, was elected vice-president of the Wisconsin Sanatorium Trustees' Association.

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Dr. Matthew J. Noon has joined the Wisconsin Anti-Tuberculosis Association as a full-time member of the medical staff. He was graduated from the Columbia University College of Physicians and Surgeons, New York, and took postgraduate work at the Trudeau School of Tuberculosis. He was formerly resident physician at Summit Park Sanatorium, Pomona, New York, and medical director of the Morgan County Tuberculosis Sanatorium, Decatur, Alabama.

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Dr. Clemens R. Kwapy has been reappointed health officer for the city of Oconto.

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Dr. Lawrence C. Davis, Richland Center, recently submitted his resignation as city health officer and milk inspector in order to accept an appointment as medical officer for the Veterans' Administration. He reported July 1 at Waco, Texas for a six weeks' course in governmental medical methods, after which he will receive a permanent assignment. The city council rejected the resignation and offered a leave of absence during the war.

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Dr. Richard E. Davies has resigned as physician at the Waukesha County Asylum for Chronic Insane. He has held the post since 1914. *Dr. Herbert F. Sydow* is his successor.

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Dr. C. A. Harper, state health officer, Madison, gave the welcoming address at the meeting on June 20 of over 100 Wisconsin sanatoria personnel comprising the Wisconsin Sanatorium Trustees' Association. Also on the program was *Dr. Ralph M. Fellows*, assistant medical director at Milwaukee

County Hospital for Mental Diseases. *Dr. Fellows* stressed the importance of giving tuberculous patients mental as well as physical care.

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Dr. Glenway L. Rothenmaier was recently appointed deputy health commissioner of the city of Racine to fill the vacancy caused by the death of *Dr. A. J. Williams.*

SOCIETY RECORDS

New Members

C. R. Cannon, Ellsworth.
A. R. Aanes, Ellsworth.
C. L. Qualls, Juneau.
D. F. Doyle, Highland.
G. H. Jurgens, Muirdale Sanatorium, Wauwatosa.
K. W. Baker, Tony.
J. D. Walsh, Muscoda.

Changes in Address

F. H. Russell, West Allis, to Little Elkhart Lake, Route 1, Plymouth.

E. J. Nagoda, Madison, to Utah State Sanatorium, Ogden, Utah.

D. M. Regan, Upper Darby, Pa., to Berlin.

K. R. Icks, Annapolis, Md., to Route 6, Green Bay.

BIRTHS

A daughter, Dale Nessa, to Dr. and Mrs. Lawrence W. Kaufman, Milwaukee, on June 12.

A son, William Allen, to Dr. and Mrs. Clemens R. Kwapy, Oconto, on May 26.

MARRIAGES

Dr. Paul W. Ryan and Miss Marian Fuss, both of Milwaukee, on May 9 in Milwaukee.

Dr. Rodney K. Peterson, San Diego, and Miss Janet Maud Nelson, Madison, on June 20 in Madison.

DEATHS

Dr. Joseph Chandler, Pardeeville, died suddenly upon arrival in Milwaukee on June 16 where he expected to enter a hospital for medical treatment. He was 76 years of age.

He was graduated in 1889 from Northwestern University Medical School, Chicago, and was a member of the Columbia–Marquette–Adams County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Dr. Chandler is survived by his widow, a daughter and a son.

Dr. Louis Dorpat, former superintendent of the Milwaukee South View Isolation Hospital, died May 25 at Milwaukee County Hospital after an illness of several days. He was 70 years old.

Born at Stringtown, Missouri, Dr. Dorpat came to Wisconsin with his parents as a child. He was graduated from Concordia College in Milwaukee and obtained his medical degree in 1905 from the Milwaukee Medical College.

For three years Dr. Dorpat practiced medicine in Milwaukee. Then he moved to Oakwood, in Milwaukee County, where he practiced for eleven years. In 1916 he was appointed a deputy state health officer, and he served at Rhinelander until 1924, when he received a similar appointment as health officer at Ironwood, Michigan. Eight years later Dr. Dorpat was appointed superintendent of South View Isolation Hospital, Milwaukee, where he remained until his retirement on August 30, 1941.

Dr. Dorpat was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him besides his widow are three sons, William and Frederick, both of Ironwood, and Robert, Milwaukee; three daughters, Mrs. Elsie Walling, Manitowoc; Mrs. Gretchen Peterson, Two Rivers, and Mrs. Edith Stephens, Milwaukee; a sister, Mrs. Louis Frank, Arapahoe, Nebraska, and a brother, Chris, Marshfield.

Dr. Charles M. Griswold, a member of the medical staff of the Soldiers' Home in Milwaukee until two months ago, died on June 12 at the age of 68. He had retired from his work in April because of ill health.

A veteran of both the Spanish-American and the World War, Dr. Griswold was a major in the army medical reserve corps. He had served for fifteen years with the Veterans' Administration and was on the Soldiers' Home staff for five years.

Returning from the Spanish-American War, Dr. Griswold worked his way through Marquette University as a telegrapher. He received his degree from the Medical School in 1910. Before he went to France as a lieutenant in the medical corps in the World War Dr. Griswold had practiced medicine in Wabeno, Princeton, Plymouth and Alma Center. After the Armistice he opened an office in Clintonville, where he remained until he entered the Veterans' Administration service in 1927. He served in Hampton, Virginia; Hot Springs, South Dakota, and Danville, Illinois before taking up his duties at the Soldiers' Home in Milwaukee.

Dr. Griswold was formerly a member of the Trempealeau–Jackson–Buffalo, Waupaca, and Sheboygan County Medical Societies, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow; a son, Leland of Milwaukee; a brother, J. B. of Eau Claire; a half brother, Leslie of Monticello, Indiana, and a half sister, Mrs. Grace Whiffen of Sheboygan.

Dr. Hans A. Reinhard, a Milwaukee physician since 1905 and a member of St. Mary's Hospital staff, Milwaukee, for more than thirty-five years, died on June 8. He was 63 years of age.

A native of Milwaukee, Dr. Reinhard studied at the University of Wisconsin and was graduated from Rush Medical College. Following a year of medical research in Europe, Dr. Reinhard returned to Milwaukee where he practiced for some time with his father, the late Dr. Louis Reinhard. In 1924 he established his own offices in downtown Milwaukee.

Dr. Reinhard is survived by a sister, Miss Anna Reinhard of Milwaukee.

Dr. Edward R. Ryan, Milwaukee, died suddenly of a heart attack at his home on June 7 at the age of 49. Just four days previously he had attended the twenty-fifth anniversary party of the 1917 graduating class of the Marquette University Medical School.

A native of Milwaukee, Dr. Ryan joined the armed service in the World War immediately after graduation and was with the American naval units sent to the North Sea to work with the English fleet. At the time of his death he was a commander in the naval reserve.

Since 1920 Dr. Ryan had been an eye, ear, nose and throat specialist in Milwaukee and had conducted considerable research in eye diseases. He was an associate professor of eye diseases at Marquette University, director of the eye clinic at the Milwaukee County Dispensary, and a diplomate of the American Board of Ophthalmology. He held membership in the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Dr. Ryan is survived by his widow; two sons, Edward, Jr. and Daniel; two daughters, Mary and Margaret; his father, Daniel F. Ryan; one brother, Joseph F. Ryan, and two sisters, Mrs. John Carpenter and Mrs. Joseph Carpenter.

Dr. Philip Schmitt, a practicing physician in Milwaukee for more than fifty years, died on May 26 following a long illness. He was 82 years of age.

A lifelong resident of Milwaukee, Dr. Schmitt returned to that city after his graduation from Jefferson Medical College in Philadelphia. For over fifty-four years he practiced in Milwaukee and was widely known throughout the state.

Dr. Schmitt was a life member of the Medical Society of Milwaukee County, the State Medical Society, and the American Medical Association.

Surviving him are his widow; a brother, Dr. Gustav, Milwaukee, and a sister, Mrs. Lizzie Fleck, Key West, Florida.

Dr. Stephen S. Stack, Milwaukee neurologist, died at his home on May 26. He was 46 years old and had been in ill health for some time.

Recognized throughout the country as an outstanding neurologist, Dr. Stack was on the staff of Sacred Heart Sanitarium and was an assistant professor of pathology at Marquette University. He was the son of the late Dr. S. S. Stack, superintendent of Sacred Heart Sanitarium for thirty-two years. He had studied medicine at the University of Pennsylvania, at Rush Medical College, and under leading neurologists in London and Paris.

Dr. Stack was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow.

Dr. Francis J. Stirn, who had practiced medicine for fourteen years in Milwaukee, died there on May 31 at the age of 68 following a few days' illness.

Born in Lansing, Iowa, Dr. Stirn was graduated from the Milwaukee Medical College in 1907 and practiced in Cudahy for seven years. He opened the West Bend General Hospital in 1914 and was affiliated with it until 1918 when, as an army reserve officer, he was sent by the government to Montfort to take over the practice of a physician who had gone into the army. After the war Dr. Stirn went to Dubuque, Iowa, where he practiced until he returned to Milwaukee in 1929.

Dr. Stirn was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

In addition to his widow Dr. Stirn is survived by a son, Pvt. Francis P. Stirn, Hawaii; three daughters, Dolores, Rainildes and Margaret; five sisters, and four brothers.

OUTSTANDING SCIENTIFIC EXHIBITS

Realizing that exhibits form an important part of postgraduate medical education, the Council on Scientific Work has arranged, for the One Hundred First Anniversary Meeting, September 14, 15 and 16, the largest scientific exhibit section ever to be presented before your Society.

The exhibit prepared by Dr. Eben J. Carey, dean of the Marquette University School of Medicine and awarded the Gold Medal at the American Medical Association's annual meeting will be one of the main features. Other exhibits will cover such current subjects as civilian defense, fenestration operation for the improvement in hearing in otosclerosis, bronchoscopy, applied anatomy, and plastic surgery.

Civilian and Wartime Subjects to Be Emphasized at the First Annual Meeting of the Second Century of Medicine in Wisconsin

Preliminary Program for One Hundred First Anniversary Meeting is Announced by Council on Scientific Work

September 14, 15, 16

THE Council on Scientific Work, through Dr. Erwin R. Schmidt, takes pleasure in announcing the preliminary plans for the first annual meeting in the second century of the State Medical Society of Wisconsin. The program, which covers all the varied interests of our members, is designed to meet the postgraduate needs of the physician in wartime, both in civilian life and in the armed forces. A feature of this year's meeting is symposiums on the heart, hemorrhage, and sulfonamides, with the final afternoon being devoted to "The Physician and the War."

Special Features

The scientific exhibits, which have been found to be an increasingly effective means of postgraduate medical education, cover a varied array of subjects. The American Medical Association Gold Medal Award Exhibit by Dr. Eben J. Carey, Milwaukee, together with twenty-one other exhibits, will be displayed in the main arena of the Milwaukee Auditorium. Scheduled again are the applied anatomy exhibits of the two medical schools, the Marquette University School of Medicine and the University of Wisconsin Medical School; these were presented for the first time at the Centennial Meeting of the State Society. A complete list of the exhibits appears on page 613. Dr. C. J. Smiles, Ashland, a member of the Council on Scientific Work, is in charge of this section of the program.

The section chairmen report that a particular effort has been made to develop programs of special interest to those engaged in these specialties. The physicians in charge are: *Obstetrics and Gynecology*—Dr. Francis M. Frechette, Janesville; *Surgery*—Dr. Albert R. Tormey, Madison; *Medicine*—Dr. Gjermund Hoyme, Eau Claire; *Ophthalmology and Otolaryngology*—Dr. Reinhold O. Ebert, Oshkosh; *Pediatrics*—Dr. Francis R. Janney, Milwaukee; *Urology*—Dr. Alf H. Gundersen, La Crosse; *Cardiology*—Dr. Chester M. Kurtz, Milwaukee, and *Orthopedics*—Drs. Chester C. Schneider and Walter P. Blount, both of Milwaukee.

Sound motion pictures, another outstanding means of postgraduate medical education, will be shown during the opening and closing hours of each day's session. Dr. H. Kent Tenney, who was assigned this feature of the program, viewed a wide variety of films before deciding finally on those which are scheduled.

Under the supervision of Dr. C. J. Smiles, Ashland, the Council on Scientific Work will present a Physicians' Hobby Show in an area adjacent to the scientific exhibits. Among the exhibits to be displayed are the following:

- Howard J. Lee, Oshkosh—waterfowl photographs (See photograph on page 604)
- Raymond G. Arveson, Frederic—bells
- James J. Barrock, Milwaukee—stamps
- Paul F. Doege, Marshfield—guns
- Mynie G. Peterman, Milwaukee—Kodachrome slides
- Maurice A. Hardgrove, Milwaukee—paintings
- Emmett T. Ackerman, Gays Mills—magic
- Salvatore Megna, Milwaukee—glassware
- Arnold S. Jackson, Madison—flower motion pictures (in color)

A photograph from the collection of Dr. Howard J. Lee, Oshkosh, to be on display at Physicians' Hobby Show.

Albert Popp, Milwaukee—medical journals and books

Joseph F. Smith, Wausau—Kodachrome prints (in color)

Change of Days

The days of the meeting have been changed from the customary Wednesday, Thursday and Friday to Monday, Tuesday and Wednesday. This change was made in order to conserve time of members of the Society, particularly of the officers, delegates, and councilors who must attend numerous sessions of the House of Delegates, Council, reference committees, and other similar activities. By holding the sessions on the first three days of the week it is possible to have the initial meeting of the House of Delegates on Sunday, and with the completion of activities on Wednesday afternoon all members may return home to resume practice.

House of Delegates

The initial meeting of the House of Delegates will be held in the Schroeder Hotel on Sunday evening, September 13. Other meetings are scheduled for Monday evening and Tuesday morning. Dr. Russell M. Kurten of Racine, speaker of the House, extends a cordial invitation to all members of the Society to attend these meetings, which are open to any member who wishes to participate in the deliberations.

Smoker

On Monday evening, September 14, the Society's customary smoker will be held at the Schroeder Hotel. Talented entertainers and refreshments appropriate to the occasion insure an enjoyable evening.

SUNDAY EVENING, SEPTEMBER 13 . . .

6:30 House of Delegates
Banquet Room (Fifth Floor), Hotel Schroeder

MONDAY MORNING, SEPTEMBER 14 . . .

7:30 Registration
Main Arena, Milwaukee Auditorium

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Diagnosis of Early Syphilis
Diagnosis of Late Syphilis
Management of Syphilis

Symposium on the Heart

9:00 Physiology of Heart and Circulation
Walter J. Meek, Ph.D., acting dean and professor of physiology, University of Wisconsin Medical School, Madison

9:20 Physiologic Principles in Cardiac Diagnosis
Vincent Koch, Janesville

9:40 Diagnosis of Pathologic Conditions of the Heart
Arlie R. Barnes, professor of medicine, University of Minnesota Graduate School, Minneapolis–Rochester; Mayo Clinic, Rochester, Minnesota

10:00 Recess to view exhibits

10:30 Treatment of Cardiac Emergencies in the Home
Francis D. Murphy, clinical professor of medicine, Marquette University School of Medicine, Milwaukee

10:50 Cardiac Treatment at the Hospital
A. G. Koehler, Oshkosh

11:10 Constricting Pericarditis
S. W. Harrington, professor of surgery, University of Minnesota Graduate School, Minneapolis–Rochester; Mayo Clinic, Rochester, Minnesota

MONDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. Treatment of Painful Feet—How to Meet the Problem
   Robert P. Montgomery, Milwaukee
2. The Physician and the War
   a. Robert E. Fitzgerald, chairman, Committee on Medical Defense, and Procurement and Assignment Service (chairman), Milwaukee
   b. Carl N. Neupert, chairman, Health Section, Service Corps, Wisconsin Council of Defense, Madison
   c. C. O. Vingom, chairman, Dane County Health Section, Service Corps, Wisconsin Council of Defense, Madison
3. Bedside Medicine and Newer Drugs
   O. O. Meyer, associate professor of medicine, University of Wisconsin Medical School, Madison
4. Cardiac Emergencies in the Home
   Chester M. Kurtz, assistant professor of medicine, University of Wisconsin Medical School, Madison
5. Amputations and Artificial Limbs
   John O. Dieterle, Milwaukee
6. Blood Transfusions and Blood Banks
   W. D. Stovall, professor of hygiene, University of Wisconsin Medical School, Madison
7. What About Vaccines and the Prevention of Common Colds?
   Thomas O. Nuzum, Janesville
8. Medical Management of Ulcers of the Stomach
   Frederick W. Madison, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee
9. Refractions in the General Office
   Ferdinand H. Haessler, Milwaukee
10. Bedside Medicine and Newer Drugs
    Francis D. Murphy, Milwaukee
11. The Cardiac Problems of the General Practitioner
    Arlie R. Barnes, Rochester, Minnesota

ROUND—TABLE LUNCHEONS (Continued)

12. What To Do About Prolonged Labor
    Carl S. Harper, assistant clinical professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison
13. Toxemia in Pregnancy
    Chairman to be announced later
14. Treatment of Skin Diseases in General Practice
    Stephan Epstein, Marshfield
15. Surgical Measures in Tuberculosis
    a. A. R. Curreri, assistant professor of surgery, University of Wisconsin Medical School (chairman), Madison
    b. W. H. Oatway, Jr., assistant professor of medicine, University of Wisconsin Medical School, Madison
16. Newer Therapy in Poliomyelitis
    a. Herman Wirka, associate professor of orthopedic surgery, University of Wisconsin Medical School (chairman), Madison
    b. Kenneth McDonough, assistant professor of pediatrics, University of Wisconsin Medical School, Madison
17. The Use of Drugs in the Treatment of Skin Diseases
    Harry Foerster, assistant professor of dermatology, University of Wisconsin Medical School, Madison, and assistant clinical professor of dermatology, Marquette University School of Medicine, Milwaukee
18. Management of Gangrene of the Extremities
    R. T. Cooksey, Madison
19. Medical Problems of the Local Health Officer
    C. A. Harper, state health officer, Madison

MONDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

Symposium on Hemorrhage

2:00 Pathologic Physiology of Hemorrhage
Frederick W. Madison, Milwaukee

2:20 Clinical Failure of Circulation—Hemorrhage and Shock
J. S. Supernaw, Madison

2:40 Treatment—Clinical Failure of Circulation—Shock
Conde F. Conroy, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee

3:00 Recess to view exhibits

3:30 The Treatment of Obstetrical Hemorrhage
Joseph M. Freeman, Wausau

3:50 The Treatment of Traumatic Hemorrhage
Arthur C. Taylor, Appleton

4:10 The Management of Nontraumatic Hemorrhage
W. A. Killins, Green Bay

4:30 Scientific motion pictures
Otoscopy in the Inflammations

MONDAY EVENING . . .

6:45 House of Delegates
Pere Marquette Room (Fifth Floor), Hotel Schroeder

8:00 Smoker
Crystal Ballroom (Fifth Floor), Hotel Schroeder

TUESDAY MORNING, SEPTEMBER 15 . . .

8:00 House of Delegates
Banquet Room (Fifth Floor), Hotel Schroeder

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Appendicitis in Children

Symposium on Sulfonamides

9:00 The Pharmacology of Sulfonamides
Harry Beckman, professor and director, department of pharmacology, Marquette University School of Medicine, Milwaukee

GENERAL SESSION (Continued)

9:20 Sulfonamides in General Practice
Charles E. Pechous, Kenosha

9:40 Sulfonamides in Surgery
Frank D. Weeks, Ashland

10:00 Recess to view exhibits

10:30 Reports of officers

10:50 Address of Dr. Francis E. Butler, Menominee, incoming president

11:10 The Clinical Applications and Complications of the Sulfonamides
Wesley W. Spink, associate professor of internal medicine, University of Minnesota Medical School, Minneapolis; assistant professor of medicine, University of Minnesota Graduate School, Minneapolis

TUESDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. Bedside Medicine and Newer Drugs
   O. O. Meyer, Madison
2. The Management of Occiput Posteriors
   E. F. Schneiders, Madison
3. Early Lesions of the Breast
   Carl Eberbach, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee
4. Toxemias of Pregnancies
   Henry J. Olson, assistant clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee
5. Endocrines in Gynecology
   John E. Haberland, Milwaukee
6. Surgical Emergencies
   Albert Tormey, Madison
7. Medical Management of Gallbladder Disease
   a. Harold E. Marsh (chairman), Madison
   b. Wesley W. Spink, Minneapolis
8. Pneumonia and Its Therapy
   a. Frederick W. Madison (chairman), Milwaukee
   b. Clayton G. Loosli, Frank Billings Medical Clinic, University of Chicago School of Medicine, Chicago
9. Hormones and Sex
   E. H. Rynearson, assistant professor of medicine, University of Minnesota Graduate School, Minneapolis–Rochester; Mayo Clinic, Rochester, Minnesota
10. Everyday Facts about Vitamins
    Elmer L. Sevringhaus, professor of medicine, University of Wisconsin Medical School, Madison
11. Surgery of the Colon
    Joseph M. King, Milwaukee
12. Toxoid Immunization for Tetanus
    John E. Gonce, professor of pediatrics, University of Wisconsin Medical School, Madison
13. Sulfonamides in Genito-Urinary Surgery
    a. Ira R. Sisk, professor of urology, University of Wisconsin Medical School (chairman), Madison
    b. W. G. Sexton, Marshfield
    c. Alf H. Gundersen, La Crosse
14. Infant Feeding
    F. R. Janney, assistant clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee; Wauwatosa
15. Roentgenology of Spinal Fractures
    a. John E. Habbe, assistant clinical professor of roentgenology, Marquette University School of Medicine (chairman), Milwaukee
    b. L. W. Paul, associate professor of radiology, University of Wisconsin Medical School, Madison
16. Fractures of the Arm
    Herman C. Schumm, associate professor of orthopedic surgery, University of Wisconsin Medical School, Madison, and clinical professor of orthopedic surgery, Marquette University School of Medicine, Milwaukee
17. Estimation of Disability in Compensation Cases
    a. Chester C. Schneider (chairman), Milwaukee
    b. Mr. Harry A. Nelson, director, Workmen's Compensation, Industrial Commission, Madison
18. Management of Epilepsy
    Theodore C. Erickson, associate professor of surgery, University of Wisconsin Medical School, Madison
19. Neurology and Everyday Diagnosis
    a. John L. Garvey, clinical professor of neurology, Marquette University School of Medicine (chairman), Milwaukee
    b. Mabel G. Masten, associate professor of neurology and psychiatry, University of Wisconsin Medical School, Madison
20. The Physician and the War
    a. R. E. Fitzgerald, Milwaukee
    b. Carl N. Neupert, Madison
    c. C. O. Vingom, Madison
21. Fractures of Wrist, Humerus, and Ankle
    a. H. Louis Greene (chairman), Madison
    b. J. T. F. Gallagher, Madison
22. Surgery of the Stomach
    F. Gregory Connell, Oshkosh
23. Bedside Medicine and Newer Drugs
    Francis D. Murphy, Milwaukee

TUESDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

2:00 Pneumonia and Chemotherapy
Clayton G. Loosli, Chicago

2:20 The New Prophylactic Measures in Tetanus
Carl N. Neupert, assistant state health officer, Madison

2:40 Resuscitation of the Newborn Infant
William C. Keettel, special postgraduate instructor and adviser in obstetrics and gynecology, State Board of Health, Madison

3:00 Recess to view exhibits

3:30 Intra-Abdominal Diverticulitis
J. J. Gramling, Jr., Milwaukee

3:50 Actual Clinical Disturbances of the Endocrine Glands
E. H. Rynearson, Rochester, Minnesota

4:10 Advances in Vitamin Therapy
Tom D. Spies, associate professor of medicine, University of Cincinnati College of Medicine, Cincinnati

4:30 Scientific Motion Pictures
Treatment of Breech Presentation

WEDNESDAY MORNING, SEPTEMBER 16 . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Skin Graft
Proctoscopic Cinematography

SECTION ON INTERNAL MEDICINE AND CARDIOLOGY . . .

Plankinton Hall, Milwaukee Auditorium
Chairman: G. Hoyme, Eau Claire

Symposium on Hypertension

9:00 Normal Range and Hereditary Factors in Hypertension
E. A. Hines, Jr., assistant professor of medicine, University of Minnesota Graduate School, Minneapolis–Rochester; Mayo Clinic, Rochester, Minnesota

9:30 Insurance Statistical Review of Hypertension
D. E. W. Wenstrand, medical director, Northwestern Mutual Life Insurance Company, Milwaukee

10:00 Recess to view exhibits

10:30 Title to be announced later
Irvine H. Page, Indianapolis

10:50 Title to be announced later
E. T. Bell, professor of pathology, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis

11:10 Summary of Hypertension and Its Evaluation
Francis D. Murphy, Milwaukee

11:30 Recess to view exhibits

SECTION ON OBSTETRICS AND GYNECOLOGY . . .

Walker Hall, Milwaukee Auditorium
Chairman: Francis M. Frechette, Janesville

9:00 Implantation of a New Pituitary Gonadotropic Hormone with Results in a Series of Cases
John Dale Owen, clinical instructor in obstetrics and gynecology, Marquette University School of Medicine, Milwaukee
Discussant:
9:20 J. W. Lambert, Antigo

9:30 The Use of Sulfonamides in Obstetrics
D. M. Gallaher, Appleton
Discussant:
9:50 Woodruff Smith, Ladysmith

10:00 Recess to view exhibits

10:30 The Management of Toxemia in the Last Trimester of Pregnancy
Warner S. Bump, Rhinelander
Discussant:
10:50 J. W. McGill, Superior

11:00 Modern Concepts of the Relation between Heart Disease and Pregnancy
Julius Jensen, assistant professor of clinical medicine, Washington University School of Medicine, St. Louis
Discussant:
11:20 Thomas O. Nuzum, Janesville

11:30 Recess to view exhibits

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Skin Graft
Proctoscopic Cinematography

SECTION ON OPHTHALMOLOGY . . .

Juneau Hall, Milwaukee Auditorium

Chairman: R. O. Ebert, Oshkosh

9:00 The Practical Use of Prisms
George P. Guibor, Chicago
Discussant:
9:20 Aubrey H. Pember, Janesville

9:30 Surgery of the Vertical Eye Muscles
John B. Hitz, Milwaukee
Discussant:
9:50 To be announced later

10:00 Recess to view exhibits

10:30 Diagnosis in Diseases of Eye Muscles
James W. White, clinical professor of ophthalmology, New York Postgraduate Medical School, Columbia University, New York
Discussant:
10:50 E. J. Zeiss, Appleton

11:00 Frequent Causes of Eye Discomfort
Ralph H. Woods, La Salle, Illinois
Discussant:
11:20 Leopold J. Friend, Beloit

SECTION ON ORTHOPEDICS . . .

North Kilbourn Hall, Milwaukee Auditorium

Chairman: Walter P. Blount, Milwaukee

9:00 The Treatment of Painful Feet in General Practice
Robert P. Montgomery, Milwaukee
Discussants:
9:20 David J. Ansfield, Milwaukee
Charles M. Ihle, Eau Claire

9:30 The Modern Treatment of Acute Osteomyelitis
A. C. Schmidt, Milwaukee
Discussants:
9:50 John O. Dieterle, Milwaukee
Lemuel D. Smith, Milwaukee

10:00 Recess to view exhibits

10:30 The Kenny Treatment of Anterior Poliomyelitis
Wallace H. Cole, professor of surgery and director of division of orthopedic surgery, University of Minnesota Medical School, and University of Minnesota Graduate School, Minneapolis
Discussants:
10:50 Walter P. Blount, Milwaukee
Robert E. Burns, professor of orthopedic surgery, University of Wisconsin Medical School, Madison

11:00 Reconstruction Surgery for the Sequelae of Anterior Poliomyelitis
Herman Wirka, Madison
Discussants:
11:20 Herman C. Schumm, Milwaukee
H. Louis Greene, Madison

11:30 Recess to view exhibits

SECTION ON PEDIATRICS . . .

South Kilbourn Hall, Milwaukee Auditorium

Chairman: F. R. Janney, assistant clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee; Wauwatosa

9:00 Recent Advances in the Treatment of Meningitis
V. J. Cordes, Wauwatosa
Discussants:
9:20 Henry Sincock, Superior
John E. Gonce, Madison

9:30 Electroencephalogram: Its Place in Pediatrics
M. G. Peterman, professor of pediatrics, Marquette University School of Medicine, Milwaukee
Discussants:
9:50 Hans W. Hefke, Milwaukee
Theodore C. Erickson, Madison

10:00 Recess to view exhibits

10:30 Control of Contagion in Childhood
Maurice Blatt, professor of pediatrics, University of Illinois College of Medicine, Chicago
Discussants:
10:50 R. P. Schowalter, assistant clinical professor of medicine, Marquette University School of Medicine, Milwaukee
E. R. Krumbiegel, city health commissioner, Milwaukee

11:00 Emotional States and Management Problems in Childhood
Bert Beverly, assistant clinical professor of pediatrics, Rush Medical College, University of Chicago, Chicago
Discussants:
11:20 Eugenia S. Cameron, State Board of Health, Madison
H. Kent Tenney, associate professor of pediatrics, University of Wisconsin Medical School, Madison

11:30 Recess to view exhibits

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Skin Graft
Proctoscopic Cinematography

SECTION ON RADIOLOGY . . .

Committee Room D, Milwaukee Auditorium

Chairman: L. W. Paul, associate professor of radiology, University of Wisconsin Medical School, Madison

9:00 Case Reports
H. W. Hefke, Milwaukee
W. T. Clark, Janesville
Theodore Sokow, Kenosha
L. V. Littig, Madison
T. J. Pfeffer, Racine
I. G. Ellis, Madison
R. P. Potter, Marshfield

10:00 Recess to view exhibits

10:30 A Technic for Iodized Oil Myelography
S. A. Morton, Milwaukee
Discussants:
10:50 E. E. Seedorf, La Crosse
L. V. Littig, Madison

11:00 The Roentgenographic Changes in Virus Pneumonia
Howard P. Doub, Henry Ford Hospital, Detroit
Discussants:
11:20 R. P. Potter, Marshfield
S. R. Beatty, Oshkosh

11:30 Recess to view exhibits

SECTION ON SURGERY . . .

Engelmann Hall, Milwaukee Auditorium

Chairman: Albert Tormey, Madison

9:00 Appendicitis: Thirty-Five Year Survey in Rock County
W. A. Munn, Janesville
T. J. Snodgrass, Janesville
T. H. Flarity, Beloit
Discussants:
9:20 Paul F. Doege, Marshfield
M. H. Wirig, Madison

9:30 Problems in the Selection, Preparation, and Use of Suture Material in General Surgery
Hilger P. Jenkins, associate professor of surgery, University of Chicago, School of Medicine, Chicago
Discussants:
9:50 Nels Werner, Eau Claire
William J. Tucker, Ashland

10:00 Recess to view exhibits

10:30 Cesarean Section
Roland S. Cron, clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee
Discussants:
10:50 William C. Keettel, Madison
E. F. Schneiders, Madison

11:00 The Present Day Treatment of Varicose Veins
H. O. McPheeters, Minneapolis
Discussants:
11:20 George G. Stebbins, Madison
Matthew A. McGarty, La Crosse

11:30 Recess to view exhibits

SECTION ON UROLOGY . . .

Committee Room A, Milwaukee Auditorium

Chairman: Alf H. Gundersen, La Crosse

9:00 Present Day Status of Hormonal Treatment for Urologic Conditions
Walter M. Kearns, Milwaukee
Discussant:
9:20 George Ewell, Madison

9:30 Castration Treatment of Carcinoma of the Prostate
W. W. Scott, Chicago
Discussant:
9:50 Charles Marquardt, assistant clinical professor of urology, Marquette University School of Medicine, Milwaukee

10:00 Recess to view exhibits

10:30 The Treatment of Urinary Tract Infections with the Sulfonamide Group of Drugs
T. L. Pool, Mayo Clinic, Rochester, Minnesota
Discussant:
10:50 H. M. Stang, Eau Claire

11:00 Report of Prostatic Surgery at the Wisconsin General Hospital in 1940–1941
Ira R. Sisk, Madison
Discussant:
11:20 Alexander D. Spooner, Milwaukee

11:30 Recess to view exhibits

WEDNESDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. Cardiac Risks in Obstetrics
   Julius Jensen, St. Louis
2. Sutures in Surgery
   Hilger P. Jenkins, Chicago
3. Injection of Varicose Veins
   H. O. McPheeters, Minneapolis
4. Cesarean Section
   Roland Cron, Milwaukee
5. Orthopedics in Children
   a. Walter P. Blount (chairman), Milwaukee
   b. Wallace H. Cole, St. Paul
6. Hematologic Aids in Pediatric Diagnosis
   Maurice Blatt, Chicago
7. Title to be announced later
8. The Roentgenographic Aspects of Diseases Affecting the Spinal and Intervertebral Discs
   H. P. Doub, Detroit
9. Title to be announced later
   Irvine H. Page, Indianapolis
10. Title to be announced later
    E. T. Bell, Minneapolis
11. Title to be announced later
    E. A. Hines, Jr., Rochester, Minnesota
12. Title to be announced later
    D. E. W. Wenstrand, Milwaukee
13. Carcinoma of the Prostate
    W. W. Scott, Chicago
14. Sinusitis and Its Management
    O. E. Van Alyea, Chicago
15. Title to be announced later
16. The Physician and the War
    a. Robert E. Fitzgerald (chairman), Milwaukee
    b. Carl N. Neupert, Madison
    c. C. O. Vingom, Madison
17. Rheumatism
    a. Milton C. Borman (chairman), Milwaukee
    b. Vincent Koch, Janesville
18. Drugs in Skin Diseases
    a. Harry R. Foerster (chairman), Milwaukee
    b. R. L. McIntosh, associate professor of dermatology, University of Wisconsin Medical School, Madison
19. Management of Occiput Posteriors
    Benjamin E. Urdan, assistant clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee
20. Hospital Administration and Practice of Medicine
    Harry W. Sargeant, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee; Milwaukee County Hospital, Wauwatosa
21. Past-Presidents' Luncheon

WEDNESDAY AFTERNOON . . .

SECTION ON OTOLARYNGOLOGY . . .

Juneau Hall, Milwaukee Auditorium
Chairman: R. O. Ebert, Oshkosh

2:00 Sulfonamides in Eye, Ear, Nose and Throat
James W. Tanner, Eau Claire
Discussant:
2:20 R. C. Lowe, Neenah

2:30 Plastic Surgery of the Head
Volney B. Hyslop, professor of oral and plastic surgery, University of Wisconsin Medical School, Madison
Discussant:
2:50 G. V. I. Brown, emeritus professor of plastic surgery, University of Wisconsin Medical School, Madison; Milwaukee

3:00 Recess to view exhibits

3:30 Allergy in Office Eye, Ear, and Throat Practice
George E. Shambaugh, Jr., associate clinical professor of laryngology and otolaryngology, Rush Medical College, University of Chicago, Chicago
Discussant:
3:50 George L. McCormick, Marshfield

4:00 Nasal Accessory Sinuses
O. E. Van Alyea, Chicago
Discussant:
4:20 Otis M. Wilson, Wausau

4:30 Indications for Bronchoscopy
John D. Steele, Milwaukee
Discussant:
4:50 A. V. Cadden, Wauwatosa

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

2:00 Theresa Rogers Memorial Lecture—War and Neuropsychiatry
Lt. Col. William C. Porter, Medical Corps, U. S. Army, Walter Reed General Hospital, Washington, D. C.

2:30 Blast Injuries
George M. Curtis, professor of surgery, department of research surgery, Ohio State University College of Medicine, Columbus, Ohio

3:00 The Treatment of Civilian War Injuries
Warren H. Cole, professor of surgery, University of Illinois College of Medicine, Chicago

Members—1942 House of Delegates

Society	*Delegate*	*Alternate Delegate*
Ashland–Bayfield–Iron	R. O. Grigsby, Ashland	C. J. Smiles, Ashland
Barron–Washburn–Sawyer–Burnett	D. L. Dawson, Rice Lake	S. O. Lund, Cumberland
Brown–Kewaunee–Door	P. R. Minahan, Green Bay	W. W. Kelly, Green Bay
	O. A. Stiennon, Green Bay	W. E. Leaper, Green Bay
Calumet	F. P. Knauf, Kiel	N. J. Knauf, Chilton
Chippewa	A. J. Somers, Chippewa Falls	J. J. Sazama, Bloomer
Clark	M. C. Rosekrans, Neillsville	H. H. Christofferson, Colby
Columbia–Marquette–Adams	H. M. Caldwell, Columbus	L. V. McNamara, Montello
Crawford	C. A. Armstrong, Prairie du Chien	H. H. Kleinpell, Prairie du Chien
Dane	A. R. Tormey, Madison	S. A. McCormick, Madison
	H. E. Marsh, Madison	A. J. Boner, Madison
	Louis Fauerbach, Madison	L. R. Cole, Madison
	A. T. Smedal, Stoughton	N. A. Hill, Madison
Dodge	A. G. Hough, Beaver Dam	W. E. Bargholtz, Reeseville
Douglas	T. J. O'Leary, Superior	H. J. Orchard, Superior
Eau Claire–Dunn–Pepin	J. C. Baird, Eau Claire	R. N. Leasum, Osseo
Fond du Lac	D. J. Twohig, Fond du Lac	J. C. Devine, Fond du Lac
Forest	H. C. Marsh, Crandon	G. E. Carroll, Laona
Grant	E. H. Spiegelberg, Boscobel	J. H. Fowler, Lancaster
Green	F. J. Bongiorno, Albany	L. E. Creasy, Monroe
Green Lake–Waushara	J. A. Kelly, Green Lake	H. C. Koch, Berlin
Iowa	S. B. Marshall, Hollandale	H. M. Walker, Dodgeville
Jefferson	G. E. Eck, Lake Mills	O. F. Dierker, Watertown
Juneau	C. A. Vogel, Elroy	A. R. Kaufman, Mauston
Kenosha	G. C. Schulte, Kenosha	W. C. Stewart, Kenosha
La Crosse	F. A. Douglas, La Crosse	A. H. Gundersen, La Crosse
Lafayette	R. B. Quinn, Darlington	Not reported
Langlade	C. E. Zellmer, Antigo	W. P. Curran, Antigo
Lincoln	R. G. Baker, Tomahawk	F. C. Lane, Merrill
Manitowoc	E. C. Cary, Reedsville	T. H. Rees, Manitowoc
Marathon	J. F. Smith, Wausau	E. E. Flemming, Wausau
Marinette–Florence	A. T. Nadeau, Marinette	H. W. Haasl, Peshtigo
Milwaukee	J. W. Truitt, Milwaukee	L. J. Van Hecke, Milwaukee
	E. L. Bernhart, Milwaukee	H. J. Farrell, Milwaukee
	J. W. Smith, Milwaukee	J. P. Conway, Milwaukee
	E. J. Carey, Milwaukee	J. J. Pink, Milwaukee
	R. A. Toepfer, West Allis	Aaron Yaffe, Milwaukee
	D. F. Pierce, Hales Corners	J. R. Regan, Milwaukee
	S. M. Markson, Milwaukee	G. S. Flaherty, South Milwaukee
	J. C. Griffith, Milwaukee	U. E. Gebhard, Milwaukee
	C. R. Marquardt, Milwaukee	M. C. Borman, Milwaukee
	Charles Fidler, Milwaukee	B. P. Churchill, Milwaukee
	Irwin Schulz, Milwaukee	M. W. Sherwood, Milwaukee
	W. M. Kearns, Milwaukee	J. E. Mulsow, Milwaukee
	C. M. Echols, Milwaukee	C. F. Conroy, Milwaukee
	W. A. Ryan, Milwaukee	F. X. McCormick, Milwaukee
	Norbert Enzer, Milwaukee	C. C. Schneider, Milwaukee
	R. F. Purtell, Milwaukee	Benjamin Lieberman, Milwaukee
	R. E. Galasinski, Milwaukee	W. L. MacKedon, Milwaukee
Monroe	C. S. Phalen, Sparta	Not reported
Oconto	A. F. Slaney, Oconto	C. R. Kwapy, Oconto
Oneida–Vilas	W. S. Bump, Rhinelander	I. E. Schiek, Rhinelander
Outagamie	G. W. Carlson, Appleton	D. W. Curtin, Little Chute
Pierce–St. Croix	Chalmer Davee, River Falls	A. E. McMahon, Menomonie
Polk	L. O. Simenstad, Osceola	K. F. Johnson, Frederic
Portage	E. E. Kidder, Stevens Point	R. J. Stollenwerk, Stevens Point
Price–Taylor	J. D. Leahy, Park Falls	H. B. Norviel, Phillips
Racine	T. C. Hemmingsen, Racine	E. J. Schneller, Racine

Society	*Delegate*	*Alternate Delegate*
Richland	George Parke, Sr., Viola	G. H. Benson, Richland Center
Rock	H. E. Kasten, Beloit	R. A. Thayer, Beloit
	W. A. Munn, Janesville	W. T. Clark, Janesville
Rusk	L. M. Lundmark, Ladysmith	W. F. O'Connor, Ladysmith
Sauk	A. C. Edwards, Baraboo	F. R. Winslow, Baraboo
Shawano	F. L. Litzen, Gresham	A. A. Cantwell, Shawano
Sheboygan	C. J. Weber, Sheboygan	A. C. Radloff, Plymouth
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Whitehall	Robert Krohn, Black River Falls
Vernon	W. M. Trowbridge, Whitehall	J. J. Rouse, Hillsboro
Walworth	E. D. Sorenson, Elkhorn	D. H. Jeffers, Lake Geneva
Washington–Ozaukee	J. G. Hoffmann, Hartford	O. J. Hurth, Cedarburg
Waukesha	J. C. Hassall, Oconomowoc	R. E. Davies, Waukesha
Waupaca	A. M. Christofferson, Waupaca	J. H. Murphy, Clintonville
Winnebago	R. A. Jensen, Menasha	A. G. Koehler, Oshkosh
Wood	K. H. Doege, Marshfield	F. X. Pomainville, Wis. Rapids
Section on Cardiology	A. W. Bryan, Madison	F. D. Murphy, Milwaukee
Section on Ophthalmology and Otolaryngology	J. K. Trumbo, Wausau	A. H. Pember, Janesville
Section on Orthopedics	H. L. Greene, Madison	R. P. Montgomery, Milwaukee
Section on Radiology	J. E. Habbe, Milwaukee	L. V. Littig, Madison

SCIENTIFIC EXHIBITS

The following scientific exhibits have been arranged by Dr. C. J. Smiles of Ashland for display at the One Hundred First Anniversary Meeting:

Applied Anatomy
Walter E. Sullivan, Ph.D., professor of anatomy, University of Wisconsin Medical School, and Walter Zeit, Ph.D., assistant professor of anatomy, Marquette University School of Medicine, Milwaukee

Bronchoscopy
Wellwood Nesbit, professor of otolaryngology, University of Wisconsin Medical School, Madison

Wheezing That Is Not Asthma
G. L. Waldbott, Detroit

Plastic Surgery
V. B. Hyslop, professor of oral and plastic surgery, University of Wisconsin Medical School, Madison

Health and Nutrition
State Medical Society of Wisconsin, Madison

Amputations
American Medical Association, Chicago

Medical Literature
Medical Library Service, Madison

Fenestration Operation For the Improvement in Hearing in Otosclerosis
George Shambaugh, Jr., associate clinical professor of laryngology and otology, Rush Medical College, University of Chicago, Chicago

Applied Medical Art
G. H. Hansmann; Frederick Madison, associate clinical professor of medicine, Marquette University School of Medicine; and Mr. John Stringer, Jr., Milwaukee

Proctoscopic Slides
J. M. Garner, Winnetka, Illinois

Cancer of the Breast
Arnold Jackson, Madison

The Use and Abuse of Barbiturates
American Medical Association, Chicago

Wisconsin Rheumatism Association

Anatomy of the Heart
Walter Zeit, Ph.D., assistant professor of anatomy, Marquette University School of Medicine, Milwaukee

Obstetric Manikin Demonstrations
Wisconsin Society of Obstetrics and Gynecology

Early Diagnosis of Tuberculosis by Radiography
Wisconsin Anti-Tuberculosis Association

Radiographic Studies
Wisconsin Roentgen Ray Society

Automobile Drivers Clinic
Motor Vehicle Department, Madison

Treatment of Traumatic Injuries of the Face
G. B. New, professor of otolaryngology and rhinology, University of Minnesota Graduate School, Minneapolis–Rochester, and J. B. Erich, Mayo Clinic, Rochester

Investigations of Sensory and Motor Centers in Fatigue and Disease
Norbert Enzer, Milwaukee

Gross Pelvic Anatomy in Relation to Gynecologic Surgery
Arthur H. Curtis, professor of obstetrics and gynecology, Northwestern University Medical School, Chicago

Experimental Ameboid Motion of Motion of Motor Nerve Plates
Eben J. Carey, dean and professor of anatomy, Marquette University School of Medicine, and Mr. Leo Massopust, Marquette University School of Medicine, Milwaukee

Ninety-Third Annual Meeting of American Medical Association

Atlantic City, June 8-12, 1942

ONE of the most outstanding meetings of the American Medical Association in recent years was the ninety-third annual session held in Atlantic City. In "The Nation at War" section of this issue of *The Journal* appears a detailed account of the remarks of the Hon. Paul V. McNutt with reference to the obligations of the medical profession in time of war. While this subject occupied much of the time of the official meeting of the delegates, other material in allied fields was given a great deal of attention.

All the Wisconsin delegates were in attendance at all sessions of the House and participated in the active work of the session. Dr. Stephen E. Gavin, Fond du Lac, was appointed by the speaker of the House of Delegates, Dr. Harrison H. Shoulders, to the Reference Committee on Legislation and Public Relations and participated in the work of that committee on numerous resolutions proposed for adoption. Dr. Joseph F. Smith, Wausau, presented a resolution on behalf of the American College of Apothecaries seeking to improve the professional appearance of pharmacies.

Dr. James C. Sargent, commander in the Navy, now stationed at San Diego, secured leave to permit his attending the session and presented to the delegates the resolution endorsed by the State Medical Society of Wisconsin calling for the publication of matters to be presented before the delegates in advance of their meeting. This resolution was referred to the Committee on Amendments to the Constitution and By-laws, which recommended that it be not adopted but that the principles contained therein be recognized as sound and followed by state associations and others wherever possible. It was felt that because many state medical associations do not meet until a few weeks prior to the meeting of the American Medical Association the resolution could not be adopted without dislocating certain established procedures of these associations.

The House of Delegates in its second and third sessions took outstanding action in the field of scientific and economic activity. Dr. Thomas A. McGoldrick, New York, presented a resolution registering the approval of the American Medical Association of the activities of the National Physicians Committee for the Extension of Medical Service. This resolution was referred to the Reference Committee on Legislation and Public Relations, which recommended a substitute resolution expressing the appreciation of the Association for the services rendered its members by the activities of outside groups of individual physicians. Dr. Stephen E. Gavin, Fond du Lac, and Dr. Henry A. Luce, Detroit, presented a minority report of the committee seeking unqualified endorsement of the McGoldrick resolution as introduced. After extensive debate the minority report of Drs. Gavin and Luce was approved by the delegates.

Of especial interest to Wisconsin was the fact that Dr. Ludvig Hektoen, Chicago, who received the Centennial Award of the State Medical Society in 1941, was voted the Distinguished Service Award of the American Medical Association by ballot of the House of Delegates.

Special Recognition

In the scientific exhibit section the Gold Medal Award in Group I was presented to Dr. Eben J. Carey, dean of Marquette University School of Medicine, who, in conjunction with Mr. Leo C. Massopust of Marquette University School of Medicine, had an exhibit relating to "Experimental Ameboid Motion of Motion of Motor Nerve Plates." Awards in Group I are made for exhibits of individual investigation, which are judged

EBEN J. CAREY, M. D.

IRWIN SCHULZ, M. D.

on the basis of originality and excellence of presentation. Dr. Carey's exhibit will also be shown at the One Hundred First Anniversary Meeting of the State Medical Society in Milwaukee on September 14, 15, and 16.

Another member of the State Medical Society who received recognition at the meeting of the American Medical Association was Dr. Irwin Schulz, Milwaukee Children's Hospital, Milwaukee. He was awarded a certificate of merit in Group II for his exhibit entitled "Wringer Injury." Group II includes exhibits which do not exemplify purely experimental studies and which are judged on the basis of excellence of presentation and correlation of facts.

Other members from Wisconsin who cooperated in the scientific program and exhibit are:

Samuel S. Blankstein, Milwaukee
Walter P. Blount, Milwaukee
Karl H. Doege, Marshfield
Norbert Enzer, Milwaukee
Hugh P. Greeley, Madison
William E. Grove, Milwaukee
John B. Hitz, Milwaukee
Arnold S. Jackson, Madison
James A. Jackson, Madison
Russell Jackson, Jr., Madison
Walter M. Kearns, Milwaukee
Hans H. Reese, Madison
Lemuel D. Smith, Milwaukee
Madeline J. Thornton, Madison
Ralph M. Waters, Madison

Registrants

The complete list of Wisconsin registrants follows:

Arveson, R. G. ---------- Frederic
Bayley, W. E. ---------- La Crosse
Black, S. B. ---------- West Allis
Blount, W. P. ---------- Milwaukee
Burgardt, G. F. ---------- Milwaukee
Carey, E. J. ---------- Milwaukee
Carey, H. W. ---------- Lancaster
Charles, J. D. ---------- Milwaukee
Coon, H. M. ---------- Madison
Derge, H. F. ---------- Eau Claire
Doege, K. H. ---------- Marshfield
Eisenberg, P. J. ---------- Milwaukee
Enzer, Norbert ---------- Milwaukee
Foerster, O. H. ---------- Milwaukee
Gabor, M. E. ---------- Milwaukee
Gavin, S. E. ---------- Fond du Lac
Greeley, H. P. ---------- Madison
Grove, W. E. ---------- Milwaukee
Gundersen, Gunnar ---------- La Crosse
Hansmann, G. H. ---------- Milwaukee
Hardgrove, Maurice ---------- Milwaukee
Harris, J. W. ---------- Madison
Heise, H. A. ---------- Milwaukee
Herzog, J. V. ---------- Milwaukee
Hitz, J. B. ---------- Milwaukee
Hoyme, Gjermund ---------- Eau Claire
Irvine, R. K. ---------- Manawa
Jackson, Russell, Jr. ---------- Madison
Jacobson, E. B. ---------- Milwaukee
Johnson, A. W. ---------- Milwaukee
Jones, G. S. ---------- Genesee Depot
Kearns, W. M. ---------- Milwaukee
Kidder, E. E. ---------- Stevens Point
Lettenberger, Joseph ---------- Milwaukee
Malin, G. F. ---------- La Crosse
Maloof, G. J. ---------- Madison
McCormick, S. A. ---------- Madison
Patterson, L. G. ---------- Waupaca
Pessin, S. B. ---------- Madison
Puestow, K. L. ---------- Madison
Quisling, A. A. ---------- Madison
Regan, J. R. ---------- Milwaukee
Ruschhaupt, L. F. ---------- Milwaukee
Sargent, J. C. ---------- Milwaukee
Sevringhaus, E. L. ---------- Madison
Schulz, Irwin ---------- Milwaukee

Schutte, A. G. ----------Milwaukee
Smith, J. F. ----------Wausau
Taylor, J. G. ----------Milwaukee
Urdan, B. E. ----------Milwaukee
Waldman, I. J. ----------Milwaukee
Waters, R. M. ----------Madison
Warschauer, Bruno ----------Milwaukee

New Officers

The president-elect, Dr. Fred W. Rankin, Lexington, Kentucky (now in the office of the Surgeon General), was inducted into office as president. Dr. James E. Paullin, Atlanta, Georgia, was named president-elect.

Other officers are: Dr. William J. Carrington, Atlantic City, New Jersey, vice-president; Dr. Olin West, Chicago, secretary (succeeds himself); Dr. Herman L. Kretschmer, Chicago, treasurer (succeeds himself); Dr. H. H. Shoulders, Nashville, Tennessee, speaker (succeeds himself), and Dr. R. W. Fouts, Omaha, vice-speaker (succeeds himself).

A detailed report of the proceedings of the Atlantic City session was published in the June 20 and 27 issues of *The Journal of the American Medical Association.* Despite the wartime problems of transportation, the total registration was 8,238, with Wisconsin being represented by fifty-three.

Chemical Tests For Intoxication

Foreword.—The following reports an actual case in court involving the use of chemical tests for intoxication. There have been several deletions made because of repetition, and there has been some editing for the sake of clarity.—HERMAN A. HEISE, M. D., Milwaukee.

State of Wisconsin : Municipal Court : Milwaukee County

STATE OF WISCONSIN,
Plaintiff,
vs.
JOHN DOE,
Defendant.

Before the HON. ----------
Municipal Judge, presiding.

CHARGE: OPERATING AUTO WHILE INTOXICATED

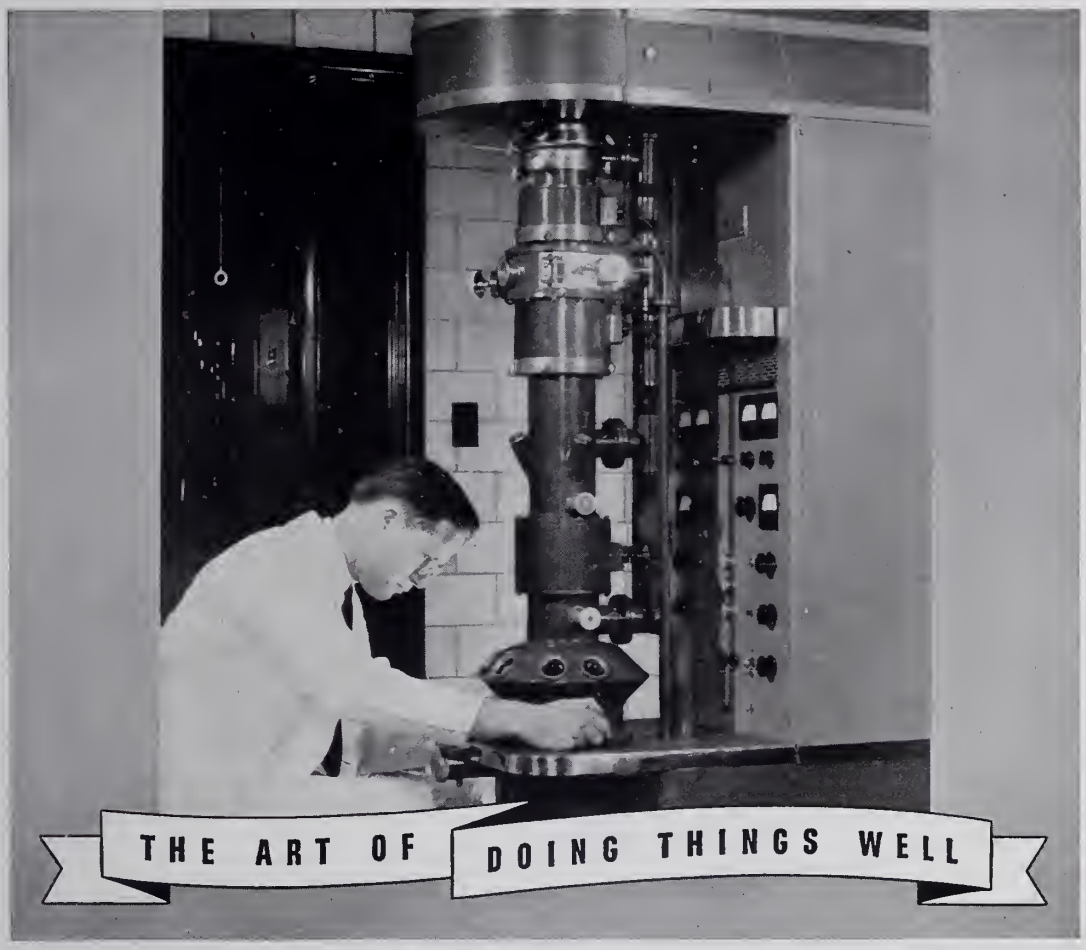
Appearances:
Assistant District Attorney, appearing for the state
---------- Attorney, appearing for the defendant
Defendant in court.

Attorney for defense: The doctor's qualifications are admitted.

Direct Examination by Assistant District Attorney

Q. Doctor, I will ask you whether or not you have made any special studies in regard to intoxication?
A. I have.
Q. Will you tell us briefly the special studies you have made in that regard?
A. I have given individuals measured amounts of alcohol and then observed their behavior, including the giving of alcohol to individuals and then having them drive cars, to see what impairment, if any, was caused by certain levels of alcohol in the body. These tests were correlated with chemical tests of blood or urine or other body fluids.
Q. Did you make a test of a urine sample delivered to you from the city chemist's office, examined by Mr. R?
A. I did.
Q. What was the alcoholic content of that urine sample delivered to you yesterday?
A. The amount of alcohol was 0.247; approximately 0.25 per cent by weight.
Q. Now, Doctor, in your special studies of intoxication you have devoted a considerable amount of study to the question of urinalysis, have you?
A. I have.
Q. Can you give an opinion as to whether a person with that amount of alcohol in the urine is under the influence of liquor?
A. I could.

(Continued on page 618)



WITH THE first microscope Leeuwenhoek saw objects magnified 200 to 300 times life-size. The familiar microscope of medical school and laboratory shows images that are, at most, 2,000 times larger than life. Now comes the electron microscope with direct magnifications of 10,000 to 30,000 times making possible clear photographic enlargements to 200,000 times life-size. There is no fine background of experience with the electron microscope, for with it objects are seen that are but a fiftieth the size of the smallest heretofore visible. But the background will be filled in as new facts are uncovered to aid in treating disease. Just now the electron microscope is contributing to the art of doing things well in research.

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Q. And what is your opinion as to whether a person with such a reading of the urine is under the influence of liquor?

A. In my opinion every person who has an alcoholic content of 0.20 or more is definitely under the influence of alcohol.

Q. Would you say that the influence of alcohol to that extent, 0.20 or over, is such as to interfere materially with his ability to drive an automobile?

A. Yes.

Q. What, for example, Doctor, would be an amount of alcohol as found in the urine that would ordinarily make a person pass out?

A. Ordinarily around 0.40 per cent.

Q. About 0.40 per cent, and this was about 0.25?

A. That's right.

Q. And what would be the effect of a higher percentage?

A. When it reaches about 0.70 per cent, death usually ensues.

Q. Can you determine, Doctor, from this amount of alcohol in the urine, the total amount of alcohol in the body of an individual?

A. I can.

Q. And assume that this defendant is a man of 130 pounds and is of the size and appearance of the defendant as he is here, can you state the amount of alcohol that was in the man's body, with that amount in the urine at the time the sample of urine was taken from his body?

A. At that time the amount of alcohol would be at least 4 ounces, absolute alcohol.

Q. A pint bottle of whiskey contains about how many ounces of alcohol?

A. If the whiskey is 100 proof whiskey?

Q. Or 50 per cent alcohol?

A. If 50 per cent alcohol, it contains 8 ounces absolute alcohol, pure alcohol, to the pint.

Q. Would it be correct to say, therefore, that the 4 ounces of alcohol in this man's body would be the equivalent of that ordinarily found in one-half pint of whiskey?

A. That's correct.

Q. Your test then, shows that the man drank 4 ounces of alcohol. Is that correct?

A. Four ounces or more.

Assistant District Attorney: I believe that's all.

Cross Examination by Counsel For the Defense

Q. Doctor, then if a man had sufficient alcohol in his urine to show the percentage you indicate, you would expect his breath to have an odor of alcohol, wouldn't you?

A. Not necessarily.

Q. Well, what would it smell from, if anything?

A. It would smell, depending upon the type of alcoholic drink taken.

Q. Well, it would smell like something?

A. Not necessarily—pure alcohol has practically no odor.

Q. What effect would the amount of alcohol that you mentioned have on the face, as to whether it were flushed?

A. It may or it may not. People differ tremendously.

Q. People differ tremendously in their ability to handle alcohol too?

A. Absolutely, that's correct.

Q. So when you come here with a yardstick and try to tell us how much alcohol one man can drink without its materially affecting his operation of a vehicle, you have to consider all men as different, don't you?

A. That's correct.

Q. A man with the build of Johnnie Weismuller and six feet tall, weighing over 200 pounds and in the prime of life and with good normal locomotion, could handle his alcohol better than a sickly, slender person?

A. As a rule that's correct, but there are some persons who are very sickly who can stand loads of alcohol, much more than some healthy persons.

Q. But certain persons who are addicted to the use of alcohol, steady drinkers, can imbibe a great deal of it and still maintain their locomotion?

A. That's correct.

(Continued on page 620)

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SCHERING

Q. To a better degree than a man who took only one drink?
A. That's possible.
Q. So that you can't put a yardstick on the amount of alcohol any individual body can handle, can you?
A. A certain yardstick, yes.
Q. Generalities?
A. Well, away from generalities. This is a specific case.
Q. How much alcohol would it take to affect a man weighing 200 pounds, 30 years of age, previously in good health, athletically inclined—how much alcohol would he have to take into his system to affect his locomotion appreciably?
A. To make a general rule as to the amount of alcohol it would take to affect a certain individual is impossible. We are not testing the amount of alcohol the person drank, we're testing the amount of alcohol the person failed to burn, and when this 200 pound man has failed to burn something between 1 and 6 ounces of alcohol, he will be under the influence of it.
Q. How do you know whether or not the body has burned up that amount of alcohol?
A. I found the alcohol in the urine unburned.
Q. So how do you know how much was burned?
A. I don't know. He may burn many times the amount that was left unburned.
Q. And from the amount he did not burn, you can state how much he originally consumed?
A. No, sir. That was not my statement. I didn't state that he took so much, but that he took *at least* so much, because I found 4 ounces of unburned alcohol. He may have taken ten times the amount which I have stated, but he took at least 4 ounces, because that was left unburned.
Q. Let me ask you this: What effect does a stimulant have on the pupils of the eyes?
A. It may have an effect on them. It may have no effect.
Q. What are the probabilities of its having an effect on the pupils?
A. The probabilities are none.
Q. Are none?
A. That's correct.
Q. Why, then, in making a test to determine whether or not a person is alcoholic, do doctors examine the eyes, if they do examine them?
A. Well, they are not looking for a stimulant.
Q. What are they looking for?
A. They are looking for the effects of alcohol.
Q. And what effects would be present?
A. The effect on the eye from the use of alcohol, which is not a stimulant.
Q. Alcohol is not a stimulant?
A. That's correct. The pupils may be perfectly normal, they are usually somewhat enlarged, they may be somewhat smaller.
Q. Why do you examine the eyes, then?
A. Because we want to give the man all the opportunity in the world to show that he is not under the influence of alcohol.
Q. And what would you find the condition of the iris to be, if he were?
A. Anything at all. It may be large or small.
Q. What is the finger-to-the-nose test?
A. That is a test in which the individual is told to close his eyes, put his arm out at right angles and then touch the tip of his nose.
Q. Why is that given?
A. It indicates the coordination of the individual, in a rather rough way.
Q. And in what way does that help in determining the alcohol in the person?
A. It's of very little value. It just tells whether or not the person has enough alcohol or enough otherwise wrong with him to make him a dangerous driver. That test alone is not diagnostic of alcohol. It is merely to determine whether or not his coordination is different from the normal. That's all it does.
Q. Does the matter of a man's swaying while he's standing still indicate anything?
A. It's also one of the symptoms that is of some importance.
Q. Neither one of these things, in and of itself, is conclusive?
A. That's correct.

(Continued on page 622)

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Q. But all of them put together are helpful?
A. They are helpful.
Q. So that if you were presented with the following situation: breath—no odor of alcohol; pupils—apparently normal; finger-to-nose test—sure; with the right hand—sure; with the left hand—sure; color of face—apparently normal; clothes—orderly; eyes—apparently normal. If you had those symptoms alone presented to you, could you say from those statements alone that the man was under the influence of liquor?
A. No, sir.
Q. If a person is able to do the finger-to-nose test correctly with both hands and touch the nose without any staggering or fluctuation he's apparently in good condition?
A. No, he just passed that particular test.
Q. Well, that's a test of locomotion?
A. It's a test of coordination and is a fair test.
Q. And coordination is one of the principal things used in the operation of an automobile?
A. That's a very important one. It is not the most important. Judgment is much more important.
Q. But coordination is the most important physical fact?
A. It is very important, yes.
Q. Well, what is more important than coordination in the operation of an automobile?
A. I would say eyesight.
Q. Of course we are assuming that a man can see, but you don't call eyesight a physical operation, do you, of the driver?
A. Oh, yes, absolutely. That demands a physical function. Light is a physical form of energy.
Q. Well, if a person is intoxicated which of the following things would you expect as to his mental state: polite, hilarious, excited, talkative, impolite, sarcastic, restless, insulting, stupefied, combative, dull or silent.
A. You could have any of them present with any condition of drunkenness or sobriety.
Q. Or any of them absent, too?
A. That's correct.
Q. So that in and of themselves these are not important?
A. They are of some value, but not diagnostic, and there isn't a single thing on that sheet which is diagnostic of drunkenness, except the alcohol test.
Q. Which sheet are you referring to?
A. The sheet prepared by the National Safety Council, which I believe you have in your hand there.
Q. So that this entire thing, Exhibit A, concerning the appearance of eyes, mental state, unusual actions, and all those things, have nothing to do in determining whether or not he's drunk?
A. Not necessarily.
Q. Why do you take them?
A. We take them for several reasons. The first is that many people show definite physical signs of abnormality.
Q. From what?
A. From various causes: fright, contact with the police, the use of various drugs, a blow on the head, diseases of various kinds, and therefore, this sheet is to protect that person against a diagnosis of drunkenness which might be made by some unsuspecting policeman who mistook the result of a blow on the head for symptoms of drunkenness.
Q. Doctor, did I understand you to say that alcohol is not a stimulant?
A. That is correct.
Q. Well, Doctor, have you heard of a drink, a beverage with alcoholic content being administered by physicians for heat prostration?
A. I have never heard of that, no, sir.
Q. Have you ever heard of an alcoholic drink being administered to revive a person?
A. I have heard of its being given for that purpose.
Q. In what cases, for instance?
A. Well, it has been given many times by physicians, with the idea that it is a stimulant.
Q. With the idea that it is?
A. Yes.

(Continued on page 624)

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Q. And your idea differs from that?
A. My idea differs from that. It isn't a stimulant.
Q. Does it have the effect of stimulating the person who gets it?
A. It may have an apparent effect.
Q. Well, that's what you are looking for?
A. No, you are just kidding yourself when you think you are stimulated.
Q. Well, it might be a good thing to tide you over until something else could be accomplished?
A. Well, it doesn't tide you over. It's not a stimulant.
Q. Is a blood test the most correct test to determine the amount of alcohol in the system?
A. Not the most correct. It's about equally correct with the urine.
Q. Isn't it recognized by the medical profession as the most certain method of determining alcoholic content?
A. It is recognized as an absolutely certain method, that's true.
Q. And it is the only absolutely certain method?
A. No, that's incorrect.
Q. What is another absolutely certain method?
A. The amount in the brain, the amount in the spinal fluid, the amount in the urine, are absolute after the first hour after drinking.
Q. You don't mean to say that the amount in the urine is an absolute test of the amount consumed by the individual?
A. It tells the minimal amount consumed. In other words, I can tell that he consumed at least so much, but not the actual amount. That never can be stated.
Q. What organs, Doctor, handle alcohol after it enters the system and before it's excreted?
A. First of all, it goes into the stomach and intestines where it is absorbed into the blood; from the blood it passes to all tissues of the body, including the brain.
Q. And is alcohol the only substance that goes immediately to the blood stream?
A. No.
Q. It is one of the few, though, isn't it?
A. No, there are several.
Q. And alcohol only becomes effective to the patient when it enters the blood stream, isn't that a fact?
A. Well, it must enter the blood stream to reach the brain.
Q. Can you say that one drink of alcohol puts you under the influence of it?
A. Not necessarily.
Q. Do two?
A. Not necessarily.
Q. It all depends on the individual, when you get down to the last analysis?
A. No, the last analysis is the examination of the body fluids.
Q. Of all the body fluids?
A. Of any body fluids.
Q. You will agree with me then that the alcohol doesn't become injurious to the human body until it enters the blood stream?
A. That's correct.
Q. Why then, Doctor, isn't a sample of the blood the truest way of determining the degree of intoxication?
A. The alcohol in the blood is an excellent criterion of intoxication, but as far as being the best test is concerned, the blood is not, because the amount in the brain is the real amount. Take a man's brains and analyze them.
Q. But that would be injurious to his person?
A. Possibly.
Q. That's the reason they don't do it?
A. Correct.
Q. But you could take a little of his blood and get the amount of alcohol just before it got to the brain, couldn't you?
A. Yes.
Q. And you would know then the amount that he had actually assimilated of the amount that he took?
A. That's correct.
Q. And you would be able to say that this man's blood actually assimilated so much alcohol?
A. That's correct.

(Continued on page 626)

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Direct Examination by Assistant District Attorney

Q. Now, with regard to this blood test and this urine test—is there any substantial difference between their accuracy?

A. No substantial difference.

Q. And the alcohol in the urine, will you state how that gets there, from what source?

A. From the blood.

Q. In other words, any alcohol in the urine is alcohol that has gone through the blood, is that correct?

A. That is correct.

Q. It isn't alcohol that got from the stomach into the bladder?

A. That is correct.

Q. But through the blood into the bladder?

A. That is correct.

Q. Does the test for alcohol in the urine have any advantages over the test for alcohol in the blood?

A. Yes.

Q. Will you explain?

A. Getting the blood specimen requires the services of a physician, who is not always available. Also the taking of the blood demands penetration of the body and may cause pain. On the other hand, the intoxicated individual usually has a full bladder and actually welcomes the opportunity to furnish a specimen. Finally, testing urine is technically less difficult than testing blood, particularly because of the large quantities of urine that are usually available.

Q. In what way may the blood test be superior to the urine test?

A. The alcohol appears in the blood before it appears in the urine. Therefore, within the first hour to an hour and a half after heavy drinking, the percentage of alcohol in the blood will be greater than the percentage in the urine.

Q. Does this mean that the urine test may give a reading which is in favor of the accused?

A. Yes.

Q. If the urine test is taken many hours after drinking has stopped, will the urine test show the true condition of the individual?

A. In my experience the delayed urine test has always given a reading for alcohol which bears a close relationship to the blood alcohol when the blood alcohol is high. This is due to the fact that persons who are unquestionably under the influence of alcohol urinate at frequent intervals, and so do not harbor alcohol in the bladder for a long time. The urine, which is a filtrate from the blood, therefore, represents an alcohol percentage which is close to that of the blood.

Q. Have you experimental evidence of the adequacy of the urine test in determining the extent of alcoholic influence?

A. Yes, a colleague who had examined several hundred persons for intoxication was able to prophesy closely the percentage of alcohol in the urine from the symptoms alone.

Q. Was he always correct?

A. His estimates were exceedingly close, but in certain cases his figures were too high, because he failed to recognize injuries, such as a fractured skull.

Q. Does not this weaken the value of the urine test?

A. On the contrary, this series of estimates showed that the test for alcohol gave a truer picture regarding alcoholic influence than could be determined from the symptoms alone. Several persons who would ordinarily have been accused of drunken driving on the basis of symptoms due to injury or disease were vindicated by the alcohol test.

Q. This question of assimilation that counsel referred to—what is meant by that?

A. Assimilation means taking up of a substance into the body and utilizing it.

Q. And if you find this percentage as you did, 0.24 of 1 per cent, in the urine, you state that the body contained at least 1 ounces of alcohol, is that right?

A. That is correct.

Q. Might that person have had more alcohol in the body?

A. Yes.

Q. That, you state, was the lowest reading?

A. That is the lowest possible figure.

Q. Now, you have also stated that alcohol is not a stimulant, but is an apparent stimulant?

A. That's correct.

(Continued on page 628)

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Q. Tell us briefly what you mean by that.

A. Alcohol is a narcotic. It immediately causes a condition in which the brain ceases to function at its best. The first stage of alcoholic intoxication is that stage in which the higher functions of the brain are affected. These are the functions that allow you to do certain things at certain times and places, according to the dictates of civilization. When alcohol acts upon this higher center, the person is removed from the inhibitions which civilization has placed upon him. He, therefore, acts in a way in which he appears to be stimulated; what really happens is that the man is under the influence of alcohol to such an extent that his lower centers are coming to the front, his upper ones having been put out of business. It is like making a car run faster downhill without the use of brakes when you are not using power.

Q. It removes the brakes, in other words?

A. It removes the brakes.

Q. Now, would you say, Doctor, that this amount of alcohol in this person's body, at least 4 ounces of pure alcohol, would materially affect his ability to drive an automobile?

A. It would.

Q. Can you give us an idea to what extent?

A. To the extent in which the individual would have a measurable loss of judgment and coordination.

Q. You say that from a person's outward physical appearance you cannot determine with 100 per cent accuracy whether he is under the influence of alcohol, is that correct?

A. That's correct.

Q. Now, briefly, can you explain what you mean by that?

A. Yes, sir. There are many conditions which will give the person the appearance of intoxication, such as a blow on the head, a tumor of the brain, insulin shock, and so on, these conditions being indistinguishable from alcoholic intoxication. All that they show is that the person has lost to some extent his ability to carry on as he normally does, but the cause of the trouble can be determined only in one way.

Q. And what is that?

A. And that is to find the actual alcohol in quantities sufficient to account for the condition.

Q. Will you state, therefore, whether the finding of a certain amount of alcohol in a person's urine or blood, or in any of these tests you have mentioned, is an absolute determination of alcoholic influence?

A. It is.

Q. As distinguished from these other things?

A. It is.

Assistant district attorney: That's all.

Recross Examination by Counsel For the Defense

Q. So that, Doctor, in a given case then, if a man accused refuses to submit to a blood or urine test, there is no way that one could say beyond a reasonable doubt that the man was intoxicated?

A. That's true.

Q. It's only then by either the urinalysis or the blood test or some other proved test that you can say that a man is drunk beyond a reasonable doubt?

A. That is true.

Q. Does the entry of alcohol into the blood stream have any effect on the heart beat?

A. There usually is a slight quickening of the pulse.

Q. And when you have a slight quickening of the pulse, what effect does that have on the blood stream itself?

A. Usually hurries it along a little.

(Continued on page 630)

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Q. And when you have a hurrying up of the blood stream, you have an exhilaration, don't you?

A. Not necessarily.

Q. Well, that's what is called an acceleration of the blood flow, isn't it?

A. Oh, acceleration? I am sorry; yes, there is an acceleration.

Q. Which means that you feel livelier and more active temporarily?

A. That's possible.

Q. Or, in other words, stimulated?

A. Well, you can call it that.

Q. Well, that's what I'll call it. Can you tell me now, if someone takes a drink of whiskey containing a half ounce of alcohol, and I take a like drink, and we both weigh the same, how much of that will be assimilated in his blood stream, and how much of my drink will be assimilated in my blood stream?

A. No, sir, I can't.

Q. No human being can, can he?

A. No.

Counsel for the defense: That's all.

Redirect Examination by Assistant District Attorney

Q. When a man is being put through a test such as counsel described here, under arrest, in a police station, and when he is under the influence of liquor, will you state whether he can, by reason of those circumstances, make a pretty good showing on these outward tests?

A. He can.

Q. Even though he has the alcohol in his system?

A. He can.

Q. Will you briefly tell us why?

(Objected to; objection sustained.)

Assistant district attorney: That's all.

Recross Examination by Counsel For the Defense

Q. What do you mean by the term "under the influence of liquor"? Will you explain that to me?

A. A person is under the influence of alcoholic liquor when he has lost to any degree some of that clearness of intellect or control of himself which he would normally possess.

Q. Isn't it a fact that the strength of will is a determining factor in that situation?

A. It is.

Q. The physical ability of the individual is a determining factor.

A. That's correct.

Q. But the most important of all is the strength of will?

A. That's very important.

Q. So that a man of strong will and good physique might imbibe an alcoholic beverage to such an extent that he would test 0.24 and still maintain good sound judgment in his management of an automobile?

A. No, that's impossible.

Q. That's impossible?

A. Absolutely impossible. There is no such person living.

Q. How much could he take and maintain his functions properly?

A. That depends on the individual.

Q. Well, what individual are you talking about?

A. Every individual. Any individual. Any individual who has over 0.20, no matter what his tolerance, no matter what his age, no matter what his size, is under the influence, because no person living can be normal with that amount.

Q. If I take one drink into my system, am I not in some degree under the influence of it?

A. Possibly.

(Continued on page 632)

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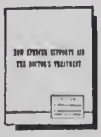

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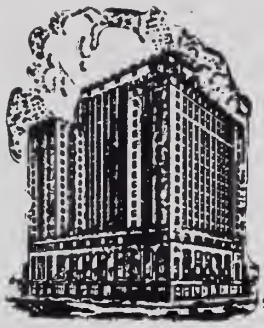

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Q. And if I take two drinks, am I not in a larger degree under the influence?
A. That's right.
Q. But when you say "under the influence," it's a relative term, isn't it, because some persons have a stronger constitution and a stronger will power, and therefore the influence exerts less results on him?
A. No, that's not entirely correct.
Q. But the will power enters into the picture?
A. It may enter into the picture when the alcohol percentage is below 0.20, but above 0.20, your will power is insufficient to make you entirely normal.

Counsel for the defense: That's all.

CORRESPONDENCE

June 12, 1942

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June 22, 1942

Miss Lucia Stolp
Assistant Editor
The Wisconsin Medical Journal
Madison, Wisconsin
Dear Miss Stolp:

The June issue of *The Wisconsin Medical Journal* published an article written by me on "Nontraumatic Rupture of a Previously Normal Spleen and Its Medicolegal Aspect." Through an oversight I failed to mention the consultants who were present in this case, and would like to correct this omission.

The consultants in the order that they were present were: Edward W. Quick, M. D., Armand J. Quick, M. D., Morris W. Sherwood, M. D., Ralph E. Morter, M. D., and John M. Usow, M. D.

The splenectomy was performed by Dr. Morter.

I would like very much to have this information added to the reprints as well as published in the next issue of *The Journal.*

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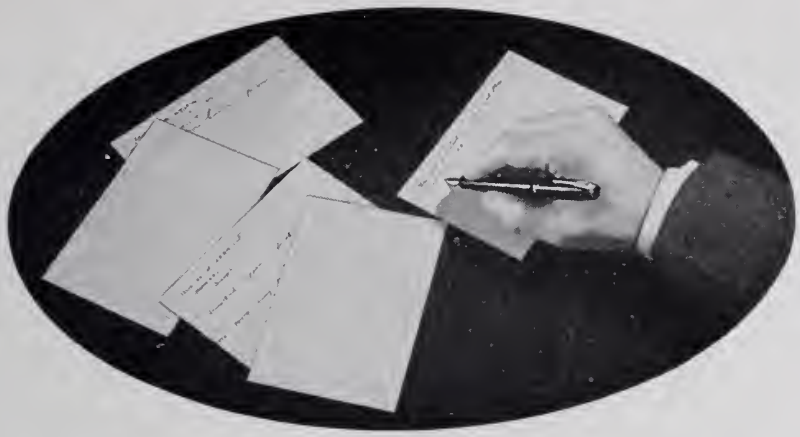

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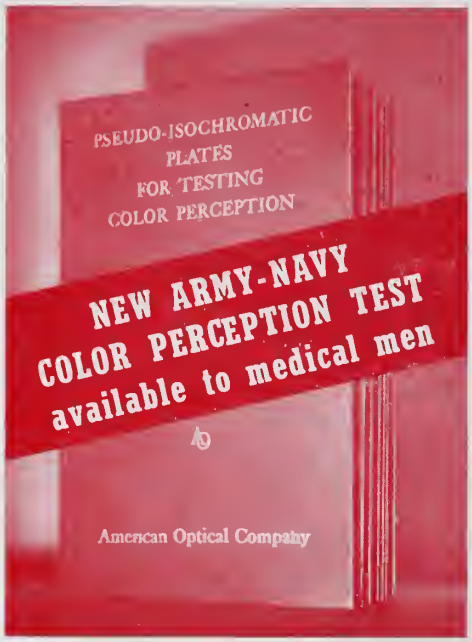

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[Entered as second class matter, June 30th, 1903, at the Post Office at Milwaukee, Wis., under Act of Congress March 3rd, 1879. Transferred to Madison, Aug. 1st, 1929.]
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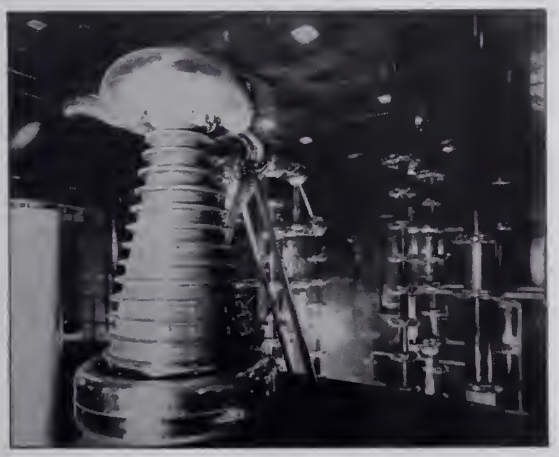

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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154—Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60 Proc. Soc. Exp. Biol. and Med., 1934, 32, 241 — N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592*

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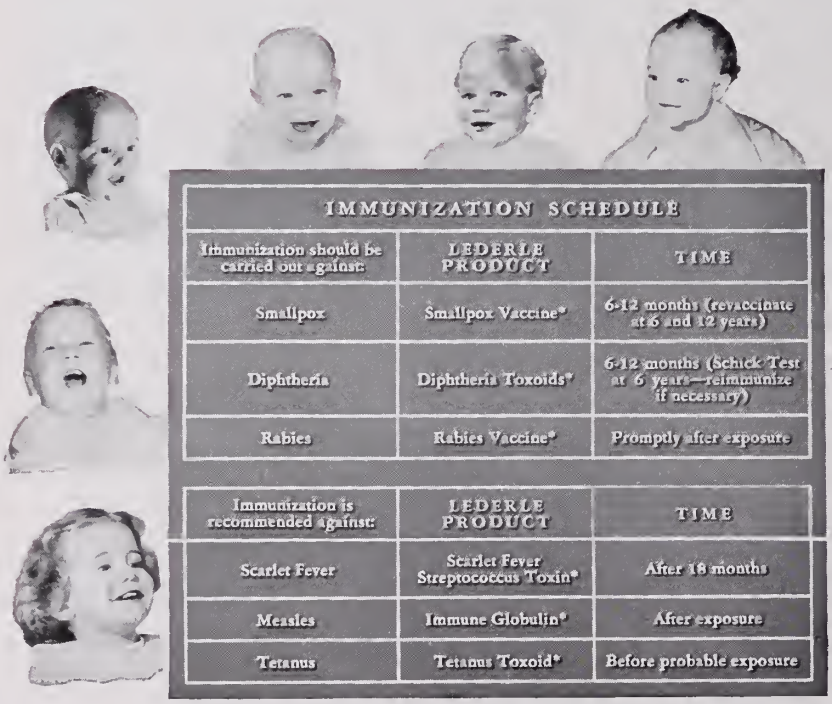
The method of diphtheria immunization most generally favored at present is 2 doses of alum precipitated toxoid or 3 doses of plain toxoid. In addition, the Department of Health of New York City has adopted the plan of urging that a single supplemental dose of 1 cc. of plain toxoid be given shortly before entering school to all children who have previously been immunized during infancy.

Smallpox incidence in 1941 reached a new low,† and public health authorities and practitioners should be proud of this attainment! However, 1,368 cases of smallpox were reported in 1941. Since this is a preventable disease, it is obvious that the goal has not yet been reached.

†Pub. Health Rep. 57:23,24 (Jan. 2) 1942.



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THE WISCONSIN MEDICAL JOURNAL

VOLUME 41, NO. 8 Copyright, 1942, by The State Medical Society of Wisconsin AUGUST, 1942

Fractures of the Spine*

By FREMONT A. CHANDLER, M. D.
Chicago

THE increasing incidence of injuries of the spine, due to motor car accidents, places the subject of such fractures in the forefront of traumatic lesions seen in every hospital. Such injuries are steadily approaching that frequency which was formerly associated only with hazardous heavy occupations, such as mining. Falls on ice, stairs, and bathtubs and impacts of heavy moving objects continue to result in spinal injuries as in the past. These injuries are now subjected to close scrutiny from both clinical and roentgenologic vantage points, and details of the injury are more fully appreciated. As a result, treatment is evolving along sounder lines.

Mechanism

The spine is a semiflexible column of vertebrae varying in shape and size and bound together by heavy ligaments and muscles. Each vertebral body is separated from those adjacent by semi-elastic, fibrous cushions, the intervertebral discs. Varying degrees of mobility are present at different levels, relatively wide ranges in the cervical and lumbar areas, and limited ranges throughout the thoracic area. Excessive movement is prevented by the checking effect of ligaments and muscles and by the impingement of the irregular bony processes attached to the posterior aspect of the vertebral body.

It is evident that movements of the spine beyond the limits of normal must be accompanied by yielding of the soft tissues or of the bony structure itself, with resulting strains, sprains, dislocations and fractures. The extent of these lesions depends upon the degree and direction of the active forces and the resistance of the tissues involved. A weak inelastic ligament or an atrophied decalcified bone obviously cannot withstand forces which might not affect normal structures.

In elderly patients or in those having an osteoporosis of other origin, fractures of the spine may occur as the result of insignificant trauma. However, the usual patient is an active, healthy individual who has encountered a violent external force in some manner or other. These same external forces result in injuries to the extremities, skull, or other parts of the body. Injuries of the spine are sometimes most difficult to detect especially in the presence of shock and trauma elsewhere.

Injury of Spinal Cord

The possibility of a spinal injury must not be overlooked for careless handling of the patient may easily complicate what otherwise might be a relatively simple lesion. The dictum of "splint them where they lie" applies to the spine as well as to other bones. The patient should not be flexed by lifting him into a car seat, but should be placed on his back on a board or carried face down on a blanket or on some similar object. Shock should be combated as soon as possible and the extent of the spinal injury determined.

The most serious complication being that of associated cord injury, it is imperative that the reflexes, muscle tone and sensation be observed and recorded. X-ray films are made preferably with portable equipment. A lumbar puncture will determine the presence or absence of a block of the neural canal. If cord or nerve involvement is absent, treat-

* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

ment may be made along conservative lines of general supportive measures, with a careful correction of any deformity and the employment of one of the accepted methods of external splinting. If the cord symptoms have been abrupt and complete, in all probability the damage is beyond repair and surgical intervention is hopeless. However, if the cord symptoms are complete and a block is present, relief of the block is indicated as soon as possible.

Treatment

In the presence of gross displacement of the vertebrae, reduction by traction and manipulation is preferable to laminectomy. If no bony deformity is evident, decompression by laminectomy is the method of choice. In order to be effective, either method of treatment must be instituted early for bony pressure on a possibly intact cord will result in a pressure necrosis. Any surgeon dealing with cord involvement should be equipped to carry out either method of approach and to apply traction, casts, or other means of fixation, as well as laminectomy.

In fractures of the spine without cord damage, the general principles of reduction and splinting are applicable as in other fractures. An unending variety of technics are described in surgical texts and in surgical journals. Because the majority of spinal fractures are the result of excessive flexion, extension of the fractured area is indicated. This may be accomplished by gradual hyperextension, by abrupt or gradual manipulation, the use of a curved frame or altered bed suspension, or by placing the patient prone and elevating the shoulders and legs preliminary to the application of a body cast to maintain reduction.

The basic feature of the extension method is the integrity and great strength of the anterior longitudinal ligament which prevents overcorrection at the site of fracture and influences a molding effect on the fragments tending to realign them. Extension should be maintained until bony repair is sufficient to withstand the load. This means a period of from three to four months if not longer. The efficiency of retentive apparatus is distinctly less in the lower lumbar or upper thoracic areas than in the upper lumbar or lower thoracic spine.

The rather prolonged period necessary for the complete ossification of callus must be kept in mind. This varies in length from three or four months to even longer. It is obvious, therefore, that protection of the injured area must be efficient until bony consolidation of the fractured area is complete. This does not mean rest in bed for the entire period for a well fitting cast or strong spinal brace will maintain a hyperextended position even though the patient is ambulatory.

Fracture of Posterior Vertebral Elements

Compression of the vertebral body as revealed in the lateral roentgenogram attracts our attention. The somewhat cylindrical contour of this structure is altered to appear wedge-shaped, with definite loss of height anteriorly. In most instances this loss of height occurs from the compression of the anterior superior portion of the vertebral body accompanied with more or less anterior displacement. Occasionally a similar defect is seen involving the anterior inferior portion of the body. In these cases the anterior longitudinal ligament remains intact and can be utilized as a check in reduction of the deformity. However, we should remember that motion between adjacent vertebrae takes place about a fulcrum formed by the nucleus pulposus in the intervertebral disc. If this fulcrum remains intact, compression of the vertebral body is accompanied by avulsion forces acting on the ligamentous and bony structures which constitute the posterior elements of the vertebra itself. Fractures of the spinous process, laminae, articular processes and facets accompanying compression of the vertebral bodies are of frequent occurrence. Such lesions are recognized only by meticulous study of well made roentgenograms taken in oblique angles as well as the usual anteroposterior and lateral views.

Multiple Fractures

The occurrence of fracture at more than one level should be kept in mind. Early operation reveals rupture of the interspinous

ligament, avulsion of the spinous processes, and fractures of the laminae and articular processes in unending variety and emphasizes the necessity of considering the relation of these possibilities to the final outcome of the spinal injury. Damage to the articular facets may produce a persistent traumatic arthritis accounting for many of the chronic complaints following vertebral fractures. On the other hand, injuries to the posterior elements may result in bony fusion at the level of spinal fracture producing the same results as surgical fixation of this area.

Intervertebral Disc

The fulcrum of motion between the vertebrae may yield to trauma by being extruded into adjacent areas, especially into the neural canal or into the cancellous substance of the vertebral body. Extrusion of the disc and of the nucleus pulposus into the neural canal has been emphasized in numerous publications during the last few years and as an entity will not be considered except in directing your attention to the great frequency of this lesion and in suggesting the distorted function resulting from the loss of the cushioning fulcrum from between vertebral bodies. These discs may be forced into the cancellous substance of the vertebral body by fracturing the limiting plate on the superior or inferior surface. In these instances the resultant loss of free motion between the vertebrae is obvious. In cases of long standing, such malfunction is reflected in the localized osteophytic reaction that occurs at the level of injury.

Fractures of the transverse processes caused by direct violence or by muscular contraction are relatively frequent in incidence in the lumbar spine but rare at other levels. These are painful in their early stages. Healing occurs by bony or fibrous union and little disability persists except in the compensation type of case. A cast limiting trunk motion affords great relief.

Spondylolisthesis

A brief consideration of spondylolisthesis introduces a somewhat controversial subject in any consideration of fractures of the spine. Two schools of thought exist as to the origin of the separate neural arch found in these cases. The older and larger school maintains that this defect is of congenital origin; the smaller and more recent school that it is the result of trauma occurring early in life, possibly in early infancy. The recognition of this lesion is important for all agree that its presence in the spine renders that structure more vulnerable to injury than normally intact vertebrae.

An incidence of from 3 to 5 per cent in all individuals indicates the significance of spondylolisthesis even though we may disagree as to the exact origin of the separate neural arch.

Decalcification

Fractures of vertebrae which are decalcified by some general or local pathologic process occur with minimal trauma. A misstep, a hard cough, or a relatively slight jolt frequently results in definite collapse of the body of the vertebra. In these cases treatment of the fracture is secondary to that of the basic pathologic process. Local or metastatic neoplasms respond fairly well to roentgenotherapy. Halisteresis of long standing metabolic disorders responds to an increased calcium intake supplemented by moderate use of vitamin D and the liberal use of hydrochloric acid.

The current treatment of some of the psychoses by shock is resulting in many fractures of the spine. Most of these spines show definite roentgenologic evidence of decalcification, a finding which might indicate some relationship betwen disturbed calcium metabolism and the psychotic manifestations.

The care of a patient who has sustained complete, irreparable cord damage associated with spinal fracture becomes a severe problem for all concerned. The disturbed bladder function calls for prompt attention. An indwelling catheter released at short intervals is of help in establishing automatic emptying of the bladder. Irrigations and changes of the patient's position aid in preventing bladder irritation.

Decubitus is to be anticipated and prevented by the use of a water or air mattress

and regular cleansing and massage of the skin.

Many patients heretofore destined to be lifelong bed invalids may be restored to a useful degree of activity by the employment of braces, crutches and surgical measures to counteract deformities and severe spastic contractions.

The salvaging of these patients calls for close attention to the many details of nursing and medical care.

Spinal fusions or bone grafting operations have a definite place in the treatment of persistent discomfort following fractures of the spine. Bony consolidation of the fracture area eliminates movement through poorly aligned joints.

Fractures of the Extremities*

By HERMAN C. SCHUMM, M. D.
Milwaukee

THE subject of "Fractures of the Extremities" covers a broad field, but the long bones of the arm and leg immediately come to mind because of their frequency of fracture, the numerous complications that may result, and the fact that occasionally the end results are poor. But equally important from the standpoint of serious complications and poor results are the fractures of the numerous small bones of the extremities, each of which is a problem unto itself.

A careful study of the end results of fractures of the bones of the extremities is interesting because so many of these poor end results can be prevented if we apply the common principles regarding fractures. All who treat fractures should know these principles, and probably do, but they are easily forgotten or overlooked.

I should like to discuss these common principles under the headings of etiology, diagnosis, and treatment.

ETIOLOGY

All fractures occur as the result of force applied to bone. This force may be applied directly to the site of the resulting fracture, as by a blow, or a bullet; or indirectly through a twist, muscle pull, or the transmission of force through one bone to another, as so often occurs in a fall.

Fractures which are the result of direct application of force are apt to be transverse or badly comminuted and are often compound. Fractures which are the result of indirect force are more apt to be simple, oblique or spiral fractures, and there is less danger of these fractures being compound. Long bones are more frequently fractured by indirect force; the smaller bones more frequently by direct force.

The long bones, because of their multiplicity of muscle attachments and their close relationship with important nerves and blood vessels, are subject to greater visible and palpable deformities and a higher frequency of complications of the neighboring structures, but because of the close association of the smaller bones with joints their fracture is of as great, or even greater, significance.

DIAGNOSIS

A correct diagnosis, which necessitates an adequate appreciation of the forces applied at the time of the injury and a thorough examination of the patient, is probably the most important factor in the treatment of fractures. This should be axiomatic. But in the survey of the reasons for poor results, an incorrect or an incomplete diagnosis stands high on the list. Why should this be true? I am sure we are all conscientious and want to do our best. But we are all human, which means that we have our periods of "ups-and-downs." Fatigue, the poor physical condition of a patient, the inherent trait of the human being of taking things for granted, and the rush of life in general, either singly or combined, may play a part

* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

in our mistakes. As the usual fracture is both simple and single, it, like the cry of "Wolf! Wolf!" plays a part in putting us off our guard.

We must develop the habit of making thorough physical examinations even on patients who have simple fractures and then, not trusting even ourselves, repeat the thorough examination within a week. Thus we can check our diagnosis, as well as the result of any treatment.

Adequate x-ray examinations are essential for both the diagnosis and the treatment. Anteroposterior and lateral views of the entire length of the fractured bone are essential for position and alignment. If the fracture is near or in a joint, a fair portion of the adjoining bone or bones should also be included. Being "Scotch" and using small x-ray films that take in only the site of the suspected fracture, stands high in the list of causes of failures, or "don'ts."

I should like to mention a case that illustrates this point.

Report of Case

A man slipped on a wet floor and fell. He had immediate pain and could not stand. He was taken to a hospital, where physical examination and x-ray examination showed a fracture of the lower and middle thirds of the right femur. With adequate Buck's extension, satisfactory healing of the femur was obtained. However, on getting up, he complained of pain and stiffness in his knee. He was given physical therapy for the knee.

As his troubles continued, a more thorough examination was made. This revealed that the weight-bearing table of the outer tuberosity of the tibia had been driven downward at the time of the original injury. This was not recognized at the time he was first examined, and when this fracture of the tibia could have been successfully treated.

Because of the lack of a thorough physical examination and adequate x-ray examination, not a single roentgenogram included the upper end of the tibia, and the end result was anything but satisfactory.

When the word "fracture" is mentioned, we immediately visualize a broken bone. The x-ray examination probably accounts for this. If we could also visualize at the same time the injuries to the soft parts, especially to the muscles, ligaments and nerves, our end results in the treatment of fractures would be greatly improved. We can help ourselves to increase this ability to recognize injuries to the soft parts by putting ourselves on record at the time of examination, stating that there are, or are not, injuries to the various muscles, ligaments or nerves in the region of the fracture.

TREATMENT

Treatment should mean the adoption of *efficient* measures to prevent further damage to an injured bone and to its surrounding soft parts, and to correct and maintain the position of the damaged parts for a period sufficient for healing to occur.

To obtain the maximum of good end results in fractures, the efficient treatment must start with first aid. Everyone who administers first aid should know what to do and how to do it. This sounds, and may be, impossible. However, much has already been done in educating the general public (that is, those who in the large majority of cases are the ones who render first aid), and if every person associated with medicine would learn and then talk first aid, further progress could be made.

From personal experience, I know what a thrill it is to the surgeon to see the increasing number of accident patients arriving at the hospital properly splinted and in improved physical condition.

The second stage in the treatment of fractures is the reduction. This may be obtained by traction alone (and here I should like to remark that when we speak of traction we always include countertraction), or by traction and manipulation, or by an open operative proceeding. In general, the more complete the reduction, the better the end results.

All patients with fractures that require manipulation should be anesthetized sufficiently to produce relaxation. In the simple types of fracture, such as a Colles' fracture, the injection of 1 per cent novocain locally is usually sufficient. This is a particularly good type of anesthetic for these cases, as many Colles' fractures occur shortly after meals. We have found sodium pentothal an ideal type of anesthetic in most cases of fracture, except for those we know are go-

ing to require a long period of anesthesia for proper reduction and immobilization.

The method of reduction depends on (1) the type of fracture: whether transverse or oblique; or whether simple or compound, (2) the location of the fracture: whether of the shaft or into a joint, (3) the age and condition of the patient, and (4) the type of fixation that is considered best for the particular fracture treated: whether traction and countertraction either active or fixed, fixation of parts by plaster casts, or open reduction of the fracture with internal fixation, as by vitallium plates, screws, ivory pegs, etc.

As a general rule, oblique fractures are satisfactorily treated by adequate traction and countertraction. In transverse fractures, one usually obtains best results with traction and manipulation, getting the ends of the fragments into apposition, after which they can be held easily in position by a cast. In simple fractures, traction sometimes with and sometimes without manipulation is indicated; whereas in compound fractures, because of the fact that the bone is already exposed, debridement and open reduction may frequently be the method used. Fractures of the shaft of a long bone are usually adequately taken care of by traction and countertraction; whereas fractures into the joint may occasionally be treated by traction and manipulation but very often have to be reduced by an open method in order to get the fragments into satisfactory position.

The age of the patient is a very important factor in determining the method of choice in reduction. Both the aged and the very young do better with conservative measures than with more radical types of reduction. The condition of the patient at the time first seen is of importance. If he is in shock, conservative measures are in order, at least for the time being, but if not, any type of measure may be used.

The type of fixation that is considered best for the particular fracture under treatment is determined by many factors, probably the first and most important one being the training and experience of the surgeon. The second important factor is the facilities at hand for the reduction, and the third, the type of fracture under treatment.

Some men treat all fractures conservatively, with traction and countertraction. As their experience develops, they obtain a particular skill in their use of traction, and usually have excellent results. Another man may have been trained in a large city hospital where the work is mainly surgery and the surgeon in charge is a man who is unusually adept in the use of a knife and of internal methods of fixation; and he may also obtain excellent results. A very good illustration of this last type of clinic is the fracture clinic at Presbyterian Hospital, New York City, under the charge of Dr. Clay Ray Murray, where all fractures, compound and simple, that require reduction are reduced by the open method and fixed by special plates and screws. The end results at this clinic are probably as good as any in the United States. The patients are gotten up early and their percentage of infections is exceedingly low.

I bring out this point not so much to illustrate that good results are obtained by operative methods as to emphasize that clinics and individuals that obtain uniformly good results by this method are few and far between. This requires an exceptional individual with well developed surgical technic and a well trained assistant staff. The average man who goes into the average hospital and expects to treat his fractures by the open reduction and internal fixation method is apt to find that headaches predominate over satisfaction when he checks the end results.

It has been my personal experience that in the vast majority of all types of fractures of the extremities, adequate traction and countertraction plus gentle manipulation have given satisfactory reduction. However, it is not always easy to obtain adequate traction. In difficult cases, let me call your attention to the Soutter apparatus devised by the late Dr. Robert Soutter of Boston. It may be your friend when in need.

Retention of the fragments in satisfactory position necessarily should follow reduction of a fracture. Here again we have a choice of methods influenced by the social condi-

tions of the patient, the equipment at hand, and the type of fracture. The methods to be considered are:

I. Traction and countertraction.
   A. Skin traction: adhesive plaster or some type of skin glue.
      1. Buck's extension.
      2. Russell's traction.
      3. Countertraction by position.
   B. Skeletal traction with Kirschner wires, Steinmann pins, ice tongs, etc.
      1. Continuous traction by weights or springs; countertraction by position.
      2. Fixed traction. Holding the desired position by incorporating two wires, one above and one below the fracture, in a plaster cast or some other form of retentive apparatus; or by the use of one Kirschner wire or Steinmann pin below the fracture to maintain traction, with position of the upper part of the extremity, as a flexed thigh or arm, to maintain countertraction.
   C. Weight of the extremity to give traction and the upright position of the body for countertraction; a method becoming more popular in the treatment of fractures of the humerus.

II. Splints, braces, plaster casts, etc.

III. Internal fixation: metal or bone screws; plates, etc.

The method of traction-countertraction is by far the oldest method used, there being many evidences of its having been employed by the ancient Egyptians and also the early Indians in this country. The method is simple and, on the whole, yields very satisfactory results. It usually confines the individual to bed for a long period of time, which means that the only ones who can have this treatment are the wealthy and those whose employment entitles them to hospitalization, such as army, navy and other government employes, and the poor, found in city, county and state governmental hospitals.

The use of splints, braces and casts permits earlier mobilization of the patient, but the method requires more skill and experience on the part of the surgeon.

The use of internal fixation requires still greater skill and experience on the part of the surgeon, but when all conditions are right it probably gives the best end results.

My method of choice for the average patient is fixed skeletal traction using two Kirschner wires fixed in a plaster cast. The position and alignment of the fragments are easily controlled, pressure sores are the rare exception, and the patient can be transported to his home within a few days, thus minimizing hospitalization. The chances of the fragments changing position are practically nil after once being fixed. After proper fixation is obtained, the treatment consists of the earliest possible mobilization of the part. By mobilization, I mean movement of the joints above and below the fracture and of the body as a whole. Movement of the fracture and bone is started as soon as callus is sufficiently strong to withstand strain, and this is followed up with massage, gentle active and passive motions of the joints found to be stiff, and the application of heat.

For treatment of compound fractures, I prefer to cleanse the wound and the surrounding areas thoroughly with green soap and ether and then do a thorough debridement. If the wound is not contaminated and if the elapsed time is not greater than six to eight hours, I close the wound and maintain the fragments in position with fixed traction using Kirschner wires above and below the site of fracture, fixed in a plaster cast. If the wound is badly contaminated, in addition to the above method I place powdered sulfathiazole and sulfanilamide directly in the wound and do not close the wound as tightly as I would a cleaner one. In the treatment of all compound wounds, I consider a thorough debridement of greater importance than any chemical agent.

SUMMARY

In summing up the treatment of fractures of the extremities, I find that to get the

best results the following points should be observed:

1. Make thorough, careful, repeated examinations of the patient to make certain of the diagnosis.

2. Do not stint on x-rays; have enough views, with sufficient length of the extremity.

3. Choose the method of reduction and fixation for which you and the conditions present are best prepared.

4. Check the position of the fragments at least once after reduction, the best time being at the end of the first week.

5. Fractures of the long bones, unless transverse, require traction and countertraction or adequate internal fixation to maintain position, a condition which is overlooked more frequently than any other one point.

Fractures of the Os Calcis*

By J. O. DIETERLE, M. D.
Milwauke

EXCEPTING the rare instances of fractures of the upper portion of the tuberosity producing the "open beak" appearance in the roentgenogram, and those of the sustentaculum, fractures of the os calcis may be classified under the following main types:

1. Linear fractures of the tuberosity or of the body of the calcaneum in which no widening or displacement of bone or of alteration in the salient angle can be demonstrated in the roentgenogram.

2. Compression fractures of the body with comminution and lessening of the salient angle, with or without eversion of the tuberosity.

3. Comminuted or compression fractures of the anterior portion of the bone involving the calcaneocuboid joint.

4. Compound fractures of the os calcis.

The salient angle should be determined in every instance by an inspection of the lateral roentgenograms. It is formed by the intersection of two lines projected on the upper edges of the superior processes. The normal angle is between 35 and 40 degrees (fig. 1). Any appreciable lessening of this angle indicates gross displacement of fragments, and treatment cannot be considered adequate unless an attempt is made to restore the proper relationship. It is fair to say that if the angle can be largely restored a reasonably good result may be expected.

* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

Treatment of Linear Fractures Without Alteration in Contour

Simple immobilization in a close-fitting cast from toes to knee with the plaster carefully moulded under the arch and the forefoot slightly pronated is all that is necessary. A walking iron is attached and weight bearing may be allowed. The apparatus is removed in one month, after which weight bearing is continued with a boot into which an arch support has been inserted. The prognosis in this type of fracture is good with no restriction of subastragalar motion, and there should be no percentage of permanent disability.

Compression Fractures of the Body With Alteration in Contour

By far the greater number of fractures of the os calcis fall under this heading. In nearly every case the injury is produced when the individual lands squarely on the heels in a fall from an elevated place. In rare instances the fracture may be produced by a crushing blow over the top of the foot, with the astragalus being driven into the body of the os calcis. The tuberosity is elevated and may be driven forward into the body. In some cases one may find eversion of the tuberosity.

As a rule, a roentgenogram of the heel taken from behind in anteroposterior view will show considerable widening with bone projected laterally under the external malle-

olus. Both malleoli lie closer to the bottom of the heel. The salient angle is depressed and may be obliterated or reversed in the severe cases (fig. 2). There may be considerable swelling and ecchymosis. If such is the case, the foot should be treated with compresses for a period of a week to ten days after which a reduction may be done. Any remaining edema is then massaged away by pressure as recommended by Boehler. One Kirschner wire is inserted in the upper and posterior portion of the tuberosity. In so doing the foot is first dorsiflexed to prevent tearing of the skin when traction is applied. A second wire is inserted through the tibia three inches above the ankle. The leg is then suspended on the reduction frame (fig. 3). By means of a winged screw the distracting force pulls the tuberosity downward and backward. Any impaction may be broken up and eversion of the heel corrected during this operation. Widening of the tuberosity if present is corrected by a compression clamp which should be released immediately. If a roentgenogram shows the reduction to be satisfactory a plaster splint is applied extending to the tibial tubercle with the wires incorporated. By this method of reduction one may be certain that the fragments will not slip and in the unilateral cases the patient may be up on crutches at once.

There are certain instances in which a reduction may be obtained by simple manipulation with the hands and by the use of a wedge followed by a moulded plaster splint. In these cases in which skeletal fixation is not used the cast should extend to mid-thigh with some knee flexion.

Immobilization must be maintained ten or twelve weeks or longer in the severely comminuted cases. Unless this is done the reduction might be nullified by an insecure union. In cases reduced by the skeletal traction method the patient should be under constant observation, and the wires must be occasionally inspected by cutting properly placed windows in the cast. Any inflammatory reaction is an indication for their removal. After removal of the apparatus a walking cast is substituted for a few weeks and later a boot with Thomas heel and arch support.

Persistent pain on weight bearing often follows healed fractures of the os calcis. This pain is due to one of two causes, namely, disarrangement of the subastragalar joint and widening of the os calcis causing impingement under the external malleolus. In fractures of the anterior portion of the body, pain may be due to injury to the calcaneocuboid joint. In such cases the period of disability may be shortened by an arthrodesis of the joints involved. The approach

Fig. 1. The normal salient angle shown by intersecting lines.

Fig. 2. Depressed salient angle shown by intersecting lines.

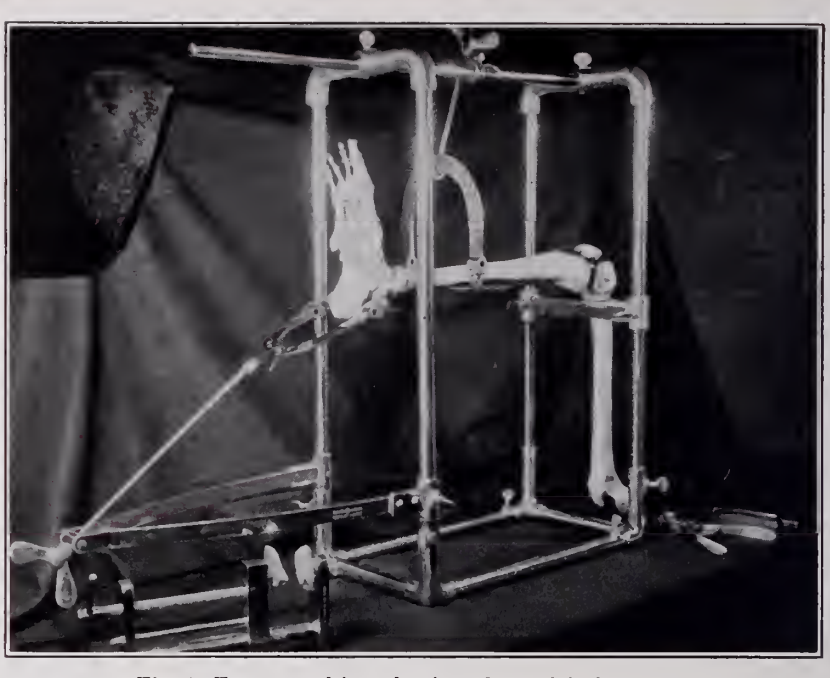

Fig. 3. Frame used in reduction of os calcis fractures.

to the subastragaloid joint is through an incision on the lateral side of the heel. After the cartilage is removed, bone chips taken from the area about the external malleolus are inserted to hasten the arthrodesis. The calcaneocuboid joint may be arthrodesed through the same incision. The foot is immobilized in plaster in slight pronation. Obliteration of all lateral motion in the foot will do away with pain and the resultant permanent disability may be estimated at 15 to 20 per cent.

Fractures of the Anterior Portion of the Body

It is important that the roentgenogram in heel fractures include views of the foot in anteroposterior and oblique directions from the sole. These views will show up fractures of the anterior portion of the os calcis which might otherwise be missed. A wooden wedge applied in the instep may be used to make the reduction in this type of fracture. It is important to know whether the calcaneocuboid joint is involved because an arthrodesis on this joint might have to be done later in case of persistent pain.

Compound Fracture of the Os Calcis

In compound fractures of the heel bone the question of reduction becomes secondary to that of the prevention of infection (fig. 4). Osteomyelitis in a heel fracture is a disaster and if there is much destruction of bone one might well contemplate an amputation with the use of an artificial leg in preference to the months or years of disability otherwise entailed, with a doubtful end result.

Careful treatment of the compound wound is imperative. Under tourniquet the wound should be incised if necessary and debrided. This is followed by prolonged flushing and the introduction of sulfanilamide or sulfathiazole powder. The wound is closed without drainage and no attempt to reduce the fracture is made until one can be assured that the danger of infection has passed. Internal medication is continued, and it is always wise to give a few injections of gas gangrene serum.

If infection should occur in spite of these precautions, a curettage must be done at a later date. The approach may be made either through the lateral surface of the heel or through a split heel incision.

The "Open Beak" Fracture of the Os Calcis

An infrequent fracture of the tuberosity is shown in figure 5. It has been called the

Fig. 4. Severe compound fracture of os calcis.

"open beak" fracture and is produced in the following manner: The patient is struck over the back of the heel while in the squatting position, the foot being in a position of sharp dorsiflexion. A leaf-like piece of bone is split off from the upper portion of the tuberosity and is displaced upward like a hinge with the posterior edge impinged against the Achilles tendon. This fragment lies above the area of insertion of the tendon and can be reduced easily by plantar flexion of the foot and the use of downward pressure over the back of the heel with the thumbs. A plaster cast holds the foot in this position until union has occurred. If there is damage to the skin the reduction of the fracture might have to be delayed. An open reduction had to be done two weeks after injury by a mid-line division of the Achilles tendon (fig. 6).

Conclusions

It might be well to recapitulate the common errors in the treatment of heel fractures, most of which are cited by Boehler:

1. Omission of lateral, oblique, and anteroposterior roentgenograms of the foot showing the anterior portion of the os calcis.

2. Omission of roentgenograms of both heels.

3. Reduction before the disappearance of swelling, which might take a week to ten days.

4. Improper placing of pins or wires in the middle of the tuberosity instead of in the

Fig. 5. The so-called "open beak" fracture of the heel.

Fig. 6. Open reduction of fracture shown in figure 5.

posterior upper portion in patients requiring skeletal fixation.

5. Omission of dorsiflexion of the foot before inserting wire or pin for skeletal traction.

6. Omission of immediate removal of the compression clamp after reduction of widening.

7. Removal of fixation before good union has occurred (ten to fourteen weeks).

8. Failure to keep patients with skeletal fixation under constant supervision and to remove the fixation if inflammation should occur.

9. Institution of massage and passive motion before it is certain there is union.

10. Omission of application of compression bandage or boot after cast is removed.

11. Omission of support to the arch on weight bearing.

12. Omission of instruction of the patient in tip-toe exercises to strengthen the calf muscles.

13. Failure to use due precaution in removal of the skeletal fixation; probing or indiscriminate curettage of a sinus might lead to infection.

14. Omission of a subastragalar arthrodesis in those patients in whom there is a persistent complaint of pain on weight bearing.

Transport and First Aid of Accident Cases*

By JOSEPH M. KING, M. D.**
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IN THIS era of speed and destructive wars the age-old task of caring for the injured is ever with us. Advances in medical knowledge have wrought changes in our method of handling accident cases with a resultant lowering of the mortality rate and the achievement of better functional end results. Most people injured in accidents are seen by general practitioners rather than surgeons, and it is to the general practitioner that we must look for the intelligent handling of first-aid work, in order that more lives and limbs be saved and permanent disability and costly hospitalization be reduced to a minimum.

Transportation

Since the advent of motorized transportation, the problem of conveying injured persons to a hospital has been solved to a great extent. In large cities the police departments or the hospitals, or a combination of both, maintain ambulances for emergency work, while in many of the smaller towns ambulances are provided by veterans' organizations or are privately owned. Practically all ambulance crews receive training in first aid and the proper manner of lifting and carrying an injured person on a stretcher. This is the ideal arrangement and rarely is there any just cause for criticism when trained men do the work. Hospital ambulances usually carry interns and this is an added advantage, for first-aid measures can sometimes be started immediately and occasionally a life is saved thereby.

Excessive speed is rarely necessary in conveying a person from the scene of an accident to the hospital. The trained ambulance driver knows this and will not substitute a screaming siren for safe driving. In the past far too many accidents occurred due to speeding ambulances, and most of them were preventable. The few minutes' time gained by wild driving usually benefits the patient not at all; on the contrary, if he is conscious, he will be in a state of nervous collapse when he reaches the hospital.

It is vitally important that an injured person be lifted and carried in the proper

* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

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manner when being taken from the scene of an accident. Injuries may be aggravated if this is improperly done. This holds true for vertebral fractures without cord involvement, in which there is irreparable damage done to the cord by the hyperflexion of the spine produced when unskilled hands lift the patient. The compounding of closed fractures of the leg bones is another catastrophe which has been known to happen.

These secondary injuries are perhaps seen more often in communities where ambulance service is not available, and pleasure cars and commercial trucks are called into service to transport patients. Sometimes, however, they are caused by the misguided efforts of excited bystanders who are present at every accident. These individuals become impatient when the ambulance does not arrive immediately after the call is placed, and then proceed to place the injured one in a private car and drive to a hospital at breakneck speed.

They are Good Samaritans of a sort, but it is incumbent upon our profession that we keep educating the public over the years to the end that eventually the work of caring for accident cases will be left to those who have received special training in it.

Every ambulance should carry a first-aid kit, several simple splints and oxygen. The oxygen can be given by means of a small, compact, inexpensive outfit, which anyone can learn to operate in a few minutes. All members of an ambulance crew should learn how to administer oxygen.

First Aid

The term "first aid" implies to some a rather hurried, makeshift treatment consisting of the pouring of an antiseptic solution into the lacerated wound and covering it with a sterile dressing, this to remain until later in the day or the next day, when the patient "will be out of shock."

Cleansing of Wound.—Adequate first-aid treatment can be given only when it is considered in the light of the healing of wounds. A clean wound heals by primary intention with little or no pain and a minimum of disability. An infected wound heals slowly by secondary intention with much pain and prolonged disability. It is the duty of the physician (and this usually means the general practitioner in accident cases) to see that bacteria are banished from the wound as soon as possible after they enter it. How can this be accomplished? The answer is easy—by the simple procedure of cleansing the wound with soap and water. The principles laid down by Koch[1] and Mason[2] in the treatment of hand injuries are applicable to practically all injuries of soft tissues and bones elsewhere in the body.

If necessary, and it usually is necessary, the patient is given some type of anesthetic. The physician scrubs his hands as for a major operation and dons sterile gloves and gown and wears a cap and a mask which covers the nose as well as the mouth, for streptococci are harbored in the nose as well as the mouth and droplet infection is a most prolific source of contamination of wounds.

The wound is then gently cleansed by repeated wipings with cotton soaked in a soap solution, followed by physiologic saline irrigations. This may be a tedious process, but almost all foreign material can be removed from the wound in this manner. All traumatized and devitalized tissue should be cut away with a sharp scalpel and all bleeding points ligated. When all this has been done the wound may be closed tightly in most instances, and healing by primary intention is the rule.

The use of strong antiseptic solutions in a wound is to be avoided, for the tissues are always damaged by this chemical trauma and healing is retarded.

At the present time there is a veritable craze for placing sulfanilamide crystals in almost every type of wound, and there are doubtless many men who cannot bring themselves to close a carefully cleansed and debrided wound without first placing some one of the sulfonamide drugs therein. These drugs will never be a substitute for careful cleansing of a wound with soap and water.

The use of rubber dam drains is frowned upon by many men, who contend that if a wound requires drainage it is better not to suture it, but to leave it wide open. Drains

sometimes act as corks and dam back exudates which turn out to be excellent culture media.

The soap and water technic is especially adapted to the treatment of abrasive scratch marks filled with dirt and cinders. Permanent scarring and disfiguring pigmentation are thus prevented. Vaseline dressings are to be used after the cleansing process, and iodine and other strong antiseptics are not to be employed.

Shock.—Secondary shock is frequently present following an accident, and it is well to remember that at times the shock is best treated by removing the cause. A fractured femur lying in a bad position in a basket splint will prolong recovery from shock, but the application of extension to the leg with relief of pain usually hastens recovery from shock.

Shock is easier to treat than it was a decade or two ago. Intravenous solutions are available in handy containers, while blood and plasma banks are being established in most hospitals and dried plasma is also to be had. The patient's bed can be heated in a few seconds by a small portable apparatus which consists essentially of a heating element and a fan which blows the heated air out through a spout tucked under the blankets.

Oxygen is now an indispensable agent in first-aid work, and is particularly useful in crushing injuries of the chest. Before the advent of oxygen therapy most of these patients were lost, but now very few of them die.

Regardless of how one may feel regarding the efficacy of antitetanic serum or the gas gangrene antitoxin or the combined serum, it is rather obligatory that it be used as a prophylactic, for it is an established procedure and failure to use it may bring repercussions at a later date. Some men prefer a therapeutic dose rather than the smaller prophylactic dose. Tests for serum sensitivity should always be made, for anaphylactic shock is a terrifying ordeal for a physician to witness, and rather difficult to explain to sorrowing relatives.

Injuries to Hands.—Injuries to the tendons and nerves of the hands are quite common and quite important, for everyone values his hands and a permanently disabled hand is a handicap which is often difficult to overcome. If one is to treat patients with these injuries intelligently, he need only to follow the rules laid down by Koch[1] and Mason,[2] those able successors of Kanavel.

They point out the absolute necessity of doing tendon and nerve repair within a space of a very few hours after injury. If the patient is not seen until many hours have elapsed the best procedure is to cleanse and close the wound and leave the tendon repair work for a later date, the length of time being dependent upon the behavior of the wound during the healing period. This means a long period of disability but the ultimate prognosis is good. It is foolhardy to take a chance and suture tendons and nerves when the wound is potentially infected, for if infection results the destructive sloughing process will carry all before it and leave nothing but a useless claw.

Examination.—First-aid treatment also includes a thorough examination of the patient. The entire body should be gone over. All too often our attention is focused upon a very obvious injury such as a laceration or a fracture, while some serious internal injury goes unnoticed. Every complaint of pain or discomfort should be investigated, for only in this way can one be certain that major injuries are not being overlooked. This holds true at times for urinary tract injuries, where there has been trauma to the pelvis and lower abdomen. Another instance of hidden injury is that of compression fractures of the vertebrae. If there is no primary cord damage, the only complaint may be "backache" and several days may pass before an x-ray film is taken which shows the fracture.

Foreign bodies frequently find their way into wounds at the time of an accident and if this possibility is kept in mind and roentgenograms are taken, the object can usually be visualized and removed. It is extremely embarrassing to have another physician in another hospital remove such a foreign body from the wound you so meticulously sutured the week before.

Conclusion

In conclusion let it be stated that first aid in accident work can be the source of much personal satisfaction to the physician if he applies these principles which have worked out so successfully. His patients will appreciate his gentle, careful handling of their wounds and they will be eternally grateful to him for a speedy, painless convalescence.

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Problems in the Diagnosis of Brain Tumors

With Report of a Case

By JOSEPH PESSIN, M. D.*

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Introduction

THE older medical practitioners were taught that headache, vomiting, and disturbed vision were the cardinal symptoms of brain tumors. More recent advances in neurophysiology have demonstrated that these symptoms are indicative of increased intracranial tension which may be caused by a variety of pathologic conditions including tumors. It is generally recognized among neurologists that the cardinal symptoms of headache, vomiting, and failing vision are often late manifestations of brain tumors and neurologists have, therefore, urged general practitioners to be "tumor-conscious" and be aware of early signs and symptoms. Bailey[1] states that there is one cardinal symptom of brain tumor, namely, "nonfebrile, steadily increasing alteration in nervous function." The alteration of nervous function may be manifold such as paresthesias, localized muscular weakness or paralysis (monoplegia), diminished hearing, loss of smell, and Jacksonian convulsions, to mention but a few.

On some occasions neurologic signs and symptoms may be absent even in the presence of a brain tumor. This is more apt to occur in the case of an infiltrating tumor in a silent area. Not infrequently one encounters mental symptoms only. These may take the form of delusions, obsessions, fears, hallucinations and other abnormal mental reactions. It then becomes necessary to determine whether the mental symptoms are due to "functional" causes such as emotional conflict from which the person is unconsciously attempting to escape, or to "organic" disease of the nervous system.

The following case illustrates difficulties in the diagnosis of brain tumors with special emphasis on the presence of mental symptoms.

Report of Case

A woman, aged 53, was admitted to the State of Wisconsin General Hospital on December 16, 1940, in an acutely agitated and fearful state. The history obtained from her husband was as follows: For several months prior to admission she was "nervous" and worried about minor incidents such as the routine farm work. Five weeks before admission she bumped into the clothesline but was not injured. Two weeks before hospitalization she became restless and developed insomnia. Her restlessness became progressively more acute, and she became fearful and suspicious. She was afraid that the hired man would injure her husband, although there was no basis for this belief. Her restlessness, fearfulness, suspiciousness and insomnia became so acute that she could no longer be kept at home, and she was hospitalized.

On admission the patient was confused, had an anxious facial expression, and was so restless that she was unable to sit in a chair. She was suspicious and gazed about intently. At night her fear was more intense and she had auditory hallucinations and delusions. On the second hospital day she was disorientated for time and place, spoke incoherently and had to be restrained in bed because of her intense agitation.

The neurologic examination, performed with difficulty, because of poor cooperation, was within normal limits. X-ray examination of the skull was negative. Lumbar puncture performed three days after her admission showed an initial pressure of 280 mm.

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Fig. 1. Anteroposterior ventriculogram. The ventricular system is shifted to the right of the midline. The left ventricle is flattened, depressed downward, and appears smaller than the right.

of water. This increased pressure was attributed to the patient's agitation and lack of cooperation. The spinal fluid was normal. The blood and spinal fluid Wassermann were negative. Ophthalmologic consultation eight days after admission showed "bilateral normal fundi."

The patient was treated conservatively with sedation and hydrotherapy to control the agitation and excitement. However, during the next two weeks she continued to manifest psychotic behavior such as auditory and visual hallucinations, delusions, fear, excitement, and agitation. As a specific illustration of her abnormal behavior the following may be cited: On January 6, she whispered, "Shut the door, shut the door. There are a lot of murderers around. They want to kill me. There was a lady out there in the hall looking in my room. Was I ever scared." She continued to speak incoherently about "the killer" and "the killer's wife."

At the request of the patient's husband, shock therapy was instituted. On January 16, one month after admission to the hospital, she was given intravenously 5 cc. metrazol (10 per cent solution). This was followed immediately by a generalized convulsion. The next day she was much improved, more lucid and less agitated. A second metrazol injection was given on January 21, but no convulsion occurred.

Following the two metrazol treatments there was a dramatic change in the patient's mental condition. Her agitation and fear disappeared. She became listless and apathetic and spent much time lying in bed. She spoke very little in contrast to her

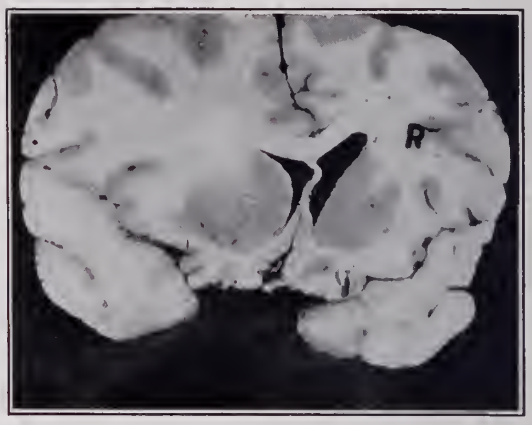

Fig. 2. Cross section of the brain showing the displacement of the ventricular system to the right and the downward displacement and compression of the left ventricle. This section was cut anterior to the site of the tumor and shows cerebral edema in the left hemisphere.

previous flight of ideas. On January 23, she developed weakness in her right hand which was associated with poor coordination on the finger-to-nose test. She began to complain of occipital headaches. On January 24, neurologic examination revealed a right monoplegia and a right hemianopsia. Examination of the fundi by the same ophthalmologist who saw the patient one month previously revealed bilateral choked discs of 3 diopters. A diagnosis of intracranial tumor was made. On January 30 a ventriculogram revealed a shift in the ventricular shadow to the right, suggesting a space filling lesion in the left cerebral hemisphere (fig. 1).

On February 1, a left temporoparietal craniotomy was performed, but no tumor was found. The patient's postoperative course was characterized by intensification of right-sided paralysis, the appearance of right facial weakness, and persistence of choked discs. Apathy merged into stupor, and she died on the sixteenth postoperative day. Autopsy performed by Dr. John C. McCarter revealed a glioblastoma multiforme in the left posterior parietal area (figs. 2 and 3).

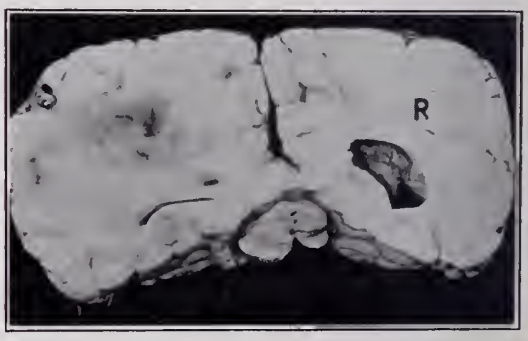

Fig. 3. Cross section showing the tumor (glioblastoma multiforme) in the left posterior parietal area.

Discussion

This case illustrates two interesting features.

First, the outstanding symptoms were "mental" and suggested a psychosis. It is true that the spinal fluid pressure was elevated, but this elevation was attributed to the patient's restlessness and poor cooperation, for it is generally known that straining and motion on the part of the patient cause marked rise in spinal fluid pressure. Also, it may be mentioned that the history indicated that she ran into a clothesline five weeks before admission. In retrospect this may have been due to visual disturbance which we were unable to detect because of her abnormal mental condition. Otherwise her neurologic examination was negative, in so far as several examiners could determine. The fundi showed no papilledema, and x-ray examination of the skull was negative.

Secondly, positive *objective* neurologic symptoms did not become evident until five weeks after her admission when she developed a monoplegia, a demonstrable hemianopsia, and choked discs.

The role of mental symptoms in the diagnosis of brain tumor is a minor one. In some instances the presence of mental symptoms may confuse rather than aid the examiner, as is indicated in this case. Not infrequently the importance of mental symptoms is determined in retrospect. After autopsy, the physician may review the clinical course and discover that the patient acted queerly or showed peculiar mental symptoms.

From a clinical point of view it is extremely important to know whether mental symptoms can be used in localizing brain tumor. Earlier writers thought this could be done. For example, Courville,[2] Kolodny,[3] and Kennedy,[4] reported that frontal lobe tumors produce mental changes which are characteristic and believed to be pathognomonic. These patients are said to be optimistic, facetious, prone to causeless laughter and apt to pun and joke (Witzelsucht). They completely lack any insight into the seriousness of their illness or the effect of their behavior on their friends and relatives.

Keschner, Bender and Strauss,[5,6] studied 85 patients with frontal lobe and 110 patients with temporal lobe tumors, and noted that the optimism, facetiousness and euphoria previously thought to be present in frontal lobe tumors were present just as frequently in temporal lobe tumors. Hence, changes in the emotional reactions are less useful in localizing a brain tumor than was formerly believed to be the case.

Certain mental symptoms do aid in the diagnosis. For example, the occurrence of complex olfactory hallucinations with uncinate seizures and a dreamy state is indicative of a tumor of the temporal lobe involving the uncinate gyrus.

The Pathogenesis of Mental Symptoms

The appearance of mental symptoms in disease of the brain and particularly in brain tumors depends on several factors some of which are demonstrable and others not yet known. That the tumor itself is of some importance is suggested by the fact that surgical removal of the tumor is frequently followed by disappearance of the mental symptoms. However, in these cases the mental symptoms may have been caused by a disturbance in the physiology of the nervous system rather than by the tumor per se. The size of the tumor alone does not explain the presence of mental symptoms, for these may be absent in large tumors and present in small ones, and vice versa.

Increased intracranial tension appears to be important in the production of mental symptoms. This is indicated by the fact that Strauss and Keschner[6] reported that 49 of their 61 cases of frontal lobe tumor with mental symptoms had increased intracranial pressure. Sometimes the severity of the symptoms appeared to be in direct relationship to the increased intracranial pressure. It has often been observed that mental symptoms can be relieved by the administration of hypertonic sucrose solutions or lumbar, cisternal, or ventricular puncture. However, increased intracranial tension alone does not account for the mental symptoms, since these are sometimes present when the cerebrospinal fluid pressure is not elevated.

The influence of known pathologic changes, such as occlusion of cerebral vessels by tumor tissue and resultant ischemia and softening of the brain, is not known. These and other

changes such as pressure necrosis are believed by some to be important factors in the production of mental symptoms. The possibility of direct toxic effects from tumor tissue or from disintegrating brain cells being important in the production of mental symptoms has also been considered by some investigators.

Finally, there are those who believe that the chief causes of mental symptoms must be sought in a careful analysis of the individual's personality. An emotionally unstable individual is more prone to develop mental symptoms when a brain tumor occurs. The brain tumor is considered the precipitating factor but not the cause of the mental symptoms.

Summary

1. A case is presented in which a malignant tumor of the left hemisphere (posterior parietal area) was associated with mental symptoms suggesting a psychosis.

2. The role of mental symptoms in the diagnosis and localization of brain tumors is discussed.

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Annual Meeting Exhibits

IN CONNECTION with the One Hundred First Anniversary Meeting of the Society, three distinct types of exhibits will be presented,—scientific, technical or commercial, and hobby.

The scientific exhibits have won for themselves a definite place in postgraduate medical education. Initially, they were regarded as a small stepchild of the annual meeting, relegated to an unimportant corner, and left to shift for themselves. Now they are recognized as one of the best methods to demonstrate certain scientific findings and data through the use of the three senses, sight, hearing and touch. Many hours of study, research and planning are represented in the completed exhibits. That which is accomplished merits all of the time and effort devoted to making them a high educational medium.

The technical or commercial exhibits likewise function as a medium of postgraduate medical education. These exhibits present specific and concrete information about drugs and supplies. Through the medium of private effort, new drugs and medical equipment have been developed in the United States to the pinnacle of perfection. Competition, research and promotion of manufacturers have further enriched our knowledge of such preparations as insulin, sulfanilamide, vitamins, endocrines and epinephrine. The technical exhibitor, like the scientific, spends many hours of study and preparation in order that his message will reach the greatest number of physicians in the shortest period of time.

The State Medical Society of Wisconsin, the American Medical Association, and medical societies throughout the United States admit to the exhibit halls only those commercial firms whose products have met the test of the Council on Pharmacy and Chemistry, the Council on Foods or the Council on Physical Therapy of the American Medical Association.

The third type of display to be presented at the One Hundred First Anniversary Meeting will be the hobbies of physicians, an exposé of methods employed by physicians to obtain relaxation from the pressure of their work and responsibilities.

The Council on Scientific Work commends to each member the threefold exhibit program which will be presented in the Main Arena of the Milwaukee Auditorium throughout the three days of the meeting.

Comments on Treatment

Editor—A. J. QUICK, M. D., Marquette University, Milwaukee

The Initial Treatment of Open Traumatic Wounds

The general practitioner today is called on to treat an ever increasing number of open traumatic wounds. The highways, the farm, the home, and industry are contributing heavily. The injured person is usually hurried to the nearest physician.

A survey of the literature and observations on methods used by various men shows a great variance in methods of treatment. The Red Cross first-aid book, which today is the most widely read book states "apply mild tincture of iodine well down into the wound." Injured persons and their friends will naturally take this as a standard by which to judge the expertness of the practitioner's method of treatment. However, Reid (New England J. Med., 215:753, 1936), in a most excellent article states "the harm which has resulted from pouring strong antiseptics into open wounds cannot possibly be estimated. It is impossible to estimate the harm and suffering which have come from the use of iodine for this purpose."

Irrespective of what method is used all agree that in treating wounds the principal object is to obtain healing by primary intention with a minimum loss of time and function and the least amount of deformity. In view of the importance of man hours in our present military program the successful treatment of wounds with prompt restoration of the patient to resume work is a direct contribution to our war effort which every practitioner can and should make.

During the last four years a method of treatment of open wounds has been used which has been most successful. The wound is treated immediately. Its treatment takes precedence over any other work at hand. The area around the wound is thoroughly cleaned with a solution of green soap. An adequate stock of this solution is always kept on hand. It is made by diluting one part of ordinary tincture of green soap with five parts of distilled water. After the area around the wound has been cleaned, the wound is opened and cleaned gently but thoroughly with this same soap solution. All devitalized tissue is removed with a sharp scissors. The wound edges are trimmed of all ragged edges and then approximated with fine silk or adhesive bridges. The wound is then covered with a strip of waxed paper and a dressing applied and the injured part splinted. No mercurial antiseptic of any sort is used.

This method of treatment has been given repeated emphasis by Koch (J. A. M. A., 107:1044, 1936), Mason (Indust. Med., 11:61, 1942), Overton (Indust. Med., 10:239, 1941), and others. These men have shown that these wounds must be treated within the first six hours, that it is most important that all devitalized tissue be removed, that the organisms leading to wound infection (save tetanus and gas bacillus) are introduced after rather than at the time of injury, that primary repair of tendons must be undertaken within two to four hours, that this requires a most metriculous technic, and that the injured part must be adequately splinted. If the wound has been contaminated with magnesium, a metal used in many of the new light alloys, all the material must be removed to prevent emphysematous development in the tissues resembling gas gangrene.

If the practitioner is to profit from the experience of these men, he can readily see that the time factor is all important. One cannot overemphasize the importance of the time factor in the treatment of traumatic wounds. If the physician should elect to refer a patient to the surgeon rather than to undertake treatment himself, he should in all fairness immediately get in touch with the surgeon in order that treatment can be instituted at once. Perhaps the introduction of sulfa drugs, judging from the experiences at Pearl Harbor, may lengthen this period during which treatment is of maximum effectiveness. Nevertheless, all effort should be made to treat the wound locally as promptly as possible. HARRY VANDER KAMP, M. D., Baraboo.

The Nation at War

In this section of *The Journal*, to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Warning Issued By State Procurement and Assignment Officer

A TIMELY warning to physicians, hospital superintendents and office managers was recently voiced by Dr. R. E. Fitzgerald, state chairman of Procurement and Assignment Service for physicians. Declaring that incidents in Wisconsin had come to his attention in which premature announcements of a physician entering service had caused local problems, Dr. Fitzgerald said: "Physicians, hospital superintendents, and office managers should be cautioned through the columns of *The Wisconsin Medical Journal* respecting the problems created under those circumstances. Many physicians, keenly anxious to serve their country, file application with the armed services and without definite knowledge of when or if they will be accepted, enter into arrangements for closing their office, selling their equipment, and notifying patients. A delay in processing the application or some similar occurrence may be encountered, with the result that the physician has unwittingly done both himself and his patients an injustice. Every physician contemplating military service should guard against this possibility."

Dr. Fitzgerald emphasized that caution should be used in publicizing the fact that a physician has been accepted for service, when no definite orders to report for duty have been issued. "Even after a physician is commissioned," said Dr. Fitzgerald, "a considerable period of time may elapse before he is called into active service. During this time the physician continues to be available to his patients and without publicity, unnecessary alarm or concern is avoided. Every physician should note that, as a routine matter, fourteen days' notice is given in the orders to report for active duty. This is sufficient opportunity to take the final steps in closing an office for the 'duration' and to permit the proper notification of patients."

Malpractice Insurance Protection Cannot Safely Be Discontinued by Medical Officers and Examining Physicians

PHYSICIANS inducted into the Army or Navy or serving as examining physicians for local boards should continue their professional liability insurance coverage, the Bureau of Legal Medicine and Legislation of the American Medical Association has advised. An editorial on this subject appearing in the September 13, 1941, issue of *The Journal of the American Medical Association* is reprinted below:

"A person in the military service may claim that an officer of the medical corps has in some manner been guilty of malpractice in treating or examining him in the line of duty. A similar claim for alleged malpractice may be pressed against an examining

physician for a local Selective Service board by a selectee called before that board. The fact that a person is in the military service, or is in the course of being inducted therein, does not prevent him from asserting his civil rights as long as the interests of the service or of national defense are not concerned. Hence the Judge Advocate General of the Army has held, quite properly, that members of the Army are entitled to the same civil rights of action between one another with reference to suits for malpractice or negligence as they would have in civil life.[1] Without doubt the same degree of care, diligence and professional ability required of any physician with respect to the care of patients in civilian life is required by law of a medical officer of the Army or of an examining physician for a local board in his care or examination of a member of the service or of a selectee called for the purposes of induction. For a departure from such standards resulting in harm to the patient the medical officer or the examining physician would be liable in a civil suit by the aggrieved patient the same as though both the patient and the physician were in civil life. The medical officer, then, in the Army and the physician acting for a local Selective Service board by virtue of his service or function stands in no different position with respect to answerability to his patients from that of a physician acting solely in a civil capacity.

"However, were a malpractice claim to be pressed against an Army medical officer or an examining physician for a local board for alleged malpractice in the performance of his official duties the government itself would no doubt provide defense for the physician accused. It has been the practice of the Attorney General in the past to provide, on the request of an interested government department or agency, defense for government officers or agents in civil suits arising out of the activities in the course of the discharge of their official duties. A communication from the office of the Judge Advocate General of the Army dated May 1, 1941 indicates that in the past the War Department itself has not undertaken the defense of a civil suit for malpractice brought against a member of the medical corps but that the defendant medical officer has had the right to have the case removed to a federal court and to be defended by a United States attorney designated by the Department of Justice. If, however, according to this communication, a judgment was to be rendered against such a medical officer, there is no provision by law by which the judgment could be paid by the government or by which the defendant physician could be reimbursed by the government.

"Similar defense in all probability would be available to a physician examining for a local Selective Service board, accused of malpractice in connection with his duties for the local board. If such a suit is filed, a communication from the Selective Service system states:

"The National Selective Service System will act as follows:

"1. Request the Attorney General to instruct the United States District Attorney to appear on behalf of the United States government or to assign a special representative of the Attorney General's office to the case.

"2. Supply expert medical testimony from our own staff.

"3. Request outstanding experts to testify without expense to the individual being sued.

"4. Cooperate in a reexamination of the registrant if such is deemed desirable.

"5. Do anything else which is within our power to assist in a thorough and complete presentation in the case in order to make certain that no unjustified claim shall succeed and,

"6. If a judgment is secured, present a bill to Congress and recommend its adoption, looking toward the paying of the judgment by the United States government.

"While the defense measures indicated that will be available to medical officers and examining physicians for local boards will undoubtedly be helpful, physicians concerned cannot safely discontinue such forms of malpractice insurance protection as they previously have carried. In the communication

[1] J. A. G. 707, March 6, 1934.

previously referred to, the Judge Advocate General's office states that malpractice suits by persons in military service against members of the medical corps have thus far been quite rare. Therefore, since patriotic cooperation may be expected from all persons and corporations during the national emergency, especially favorable premium rates should be obtainable from insurance companies for policies to protect physicians in the service and local board physicians against claims for malpractice that may rise from the performance of their duties to the service and to the national government."

Committee on War Participation Organized

FOR some months the activities and responsibilities of the medical profession of Wisconsin in preparation for war efforts were conducted through the M-Day Committee of the Council, composed of Drs. R. E. Fitzgerald, chairman, Milwaukee; Robert W. Blumenthal, Milwaukee; J. W. Lambert, Antigo; and C. N. Neupert, Madison. Subsequently, the committee was designated as the Committee on Medical Defense, but as the responsibilities of the medical profession became more complex during late months, it became evident that the committee should be reorganized more properly to permit its participation on behalf of the State Medical Society of Wisconsin and its members.

At the July Council meeting, the report of the committee was accepted to the effect it be discharged and that there be created a Council Committee on War Participation to be composed of three subcommittees, — that on Procurement and Assignment Service, on Civilian Defense and on Replacements.

The personnel of the three subcommittees will be announced in the September issue of *The Journal,* and a full report of all activities will be made before the House of Delegates at its first meeting on Sunday, September 13, in Milwaukee.

Each of the three subcommittees will be directed by its chairman and, though assigned to a particular field, will work in close collaboration with each other. The Subcommittee on Procurement and Assignment Service will serve in an advisory capacity in matters concerning general policy while the Subcommittee on Replacement will endeavor to fulfill community and state health needs as they may occur. The Subcommittee on Civilian Defense will act as a liaison with the Wisconsin Council of Defense, particularly in reference to programs involving Emergency Medical Service and general health problems.

NAMES OF MEMBERS IN SERVICE WITHHELD FOR DURATION

Prior to January, 1942, a complete list of members in service was published in *The Journal* each month. Following the declaration of war, this policy was discontinued as the Office of Censorship at Washington urged that information on the location and transfer of troops not be published. The War and Navy Departments concurred with this policy stating that frequent changes in address and assignments to destinations must be held secret to the enemy.

Therefore, for the duration of the war, a list of members in service will be maintained in the State Society's office and will be published in itsentirety at the end of the war. Through the assistance of county secretaries, news clippings and other correspondence, complete information is being compiled on each member inducted.

THE WISCONSIN MEDICAL JOURNAL

The Council on Scientific Work

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Annual Subscription ---------- Three Dollars-Fifty Cents Single Copies ---------- Fifty Cents

Advertising Representative: Cooperative Medical Advertising Bureau, 535 North Dearborn St., Chicago, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, Madison

Volume 41 — AUGUST, 1942 — Number 8

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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« « « EDITORIAL » » »

The September Meeting—A War Session

THE program for the September meeting of the State Medical Society of Wisconsin has been planned to discharge the unusual responsibility of the profession in time of war. We, as physicians, know of the demands upon us to serve the war needs of our country whether in the front lines or at home. The work each of us must do will be increased a hundredfold.

At Milwaukee, in September, members of the Society will have occasion after occasion not alone to obtain refresher lectures in scientific medicine but to hear and observe firsthand the newer developments,—those which concern the health of the people generally as well as the military in particular.

Detailed advice as well as exhibits on Emergency Medical Service in civilian defense will be offered under the able direction of Dr. John S. Coulter, Chicago, regional medical officer for the entire Sixth Civilian Defense Region.

The general subject of the physician and military service will be discussed both at round tables and elsewhere.

This, then, is not so much an annual meeting as it is a war session of the State Medical Society—a war session just as were those of the American Medical Association in Atlantic City and the American College of Surgeons.

The science of medicine is continually advancing; in times of national emergency, particularly, its achievements and its developments must be carried to the physician in as many ways as possible—the annual meeting in Milwaukee on September 14, 15, and 16 is one of them. E. R. S.

. . . . THE PRESIDENT'S PAGE . . . .

Time For Action

IN THE fateful days of August three years ago, Hitler made his decision to march on Poland. This decision was the beginning of a conflict which ultimately was to engulf the entire globe. Fundamentally it is a conflict between ideologies.

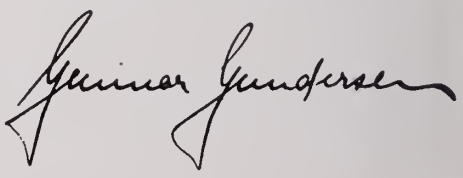
Three years ago, there were some among us of sufficient vision to sense that the all-important business of the American people was to prepare immediately to defend that which we in peace-loving America had fostered and developed over a period of more than four centuries.

The organized profession of medicine offered to do its share in this cooperative effort by setting up its own agency under government sponsorship and control. Its purpose was essentially to do a calm, deliberate, intelligent job of dealing with the quantitative and qualitative medical problems relating to the medical needs of the Army as well as those on the home front. The objectives of this agency or service were clear and unequivocal. They need not be gone into in further detail here. That they were motivated by the highest purpose, there can be no doubt. So came into being the Procurement and Assignment Service. Procurement and Assignment was exploring in a new field. Mistakes may have been committed. This is to be expected in any pioneering enterprise.

But when a man in high public office, as in the instance of Paul V. McNutt, expresses the government's dissatisfaction with what has been done thus far, based on the assumption that as yet neither government nor organized medicine has presented an adequate plan to meet our medical emergency, that no program has been submitted to satisfy both the Army and the civilian population, that only one-third as many physicians volunteered in the first six months of this war as in the corresponding period of the last war so that not even the Army has been supplied with all the doctors it must have, and threatens action by the government if more aid is not forthcoming, it is time for the rank and file of our profession to heed the warning.

Where does the explanation lie? Through the entire existence of Procurement and Assignment there has been altogether too much confusion. Your President has made a conscientious effort to orient himself in this maze. In my humble opinion, there have been too many veiled threats, too much coercion, too much "get-in-or-else attitude." Only recently have matters crystallized to a point where the physician under Selective Service has begun to understand that he has the same rights guaranteed to him as any other citizen and is entitled to classification as such. As men of science, we want to know the facts and are entitled to know them, and knowing the facts and our rights I am of the conviction that men of American medicine as patriotic citizens will act accordingly.

A wholesome change has come about in recent weeks. At the present time the attitude of those dealing with Procurement and Assignment, as well as those charged with medical enlistment, is that of appealing to the sense of duty of men in medicine. Basically, the question gets down to the fundamental concept of what do we want the future to be like. Do we want to live in a Hitler dominated and dictated world? If so, a laissez-faire or "let-George-do-it" attitude will undoubtedly be found and practiced, but if we want to perpetuate the type of civilization and the heritage handed down to us by free men, we of American medicine will forego personal gain for the time being and place ourselves and our services at the disposal of the government. It is my conviction that American medicine will not be found wanting.



MEDICINE AT HOME and IN WAR

10th anniversary PROGRAM

"The Physician at Home and in War" to Be Keynote of First Meeting in the Society's Second Century

Meeting Dates—Monday, September 14; Tuesday, September 15; and Wednesday, September 16

THE scientific program will form the bulwark of the One Hundred First Anniversary Meeting as it has since the inception of the Society in 1841. This first meeting of the second century of medicine in Wisconsin indicates that the original concept of the founders will be carried forward without interruption. Various mediums of transmitting scientific medical progress will be employed through the general sessions, specialty section meetings, and the scientific exhibits.

War Effort Stressed

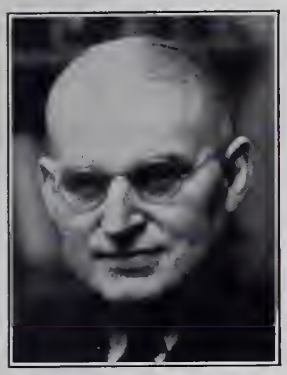
The participation of physicians in the active war effort and in Emergency Medical Service under the Office of Civilian Defense will be stressed and emphasized throughout the three-day meeting. Treatment of civilian war injuries, care of blast injuries, and neuropsychiatry in war will comprise the Wednesday afternoon program. On each of the three days, round tables will be held on Procurement and Assignment, and Emergency Medical Service. In addition, a special discussion of these subjects will be held on Monday morning, September 14, at 11:30 a. m. In the scientific exhibit section, arrangements are being made to provide physicians with authentic and reliable information on the Procurement and Assignment

Service while Dr. John S. Coulter, Chicago, regional medical officer for the Sixth Civilian Defense Region, will be in attendance at a booth devoted to Emergency Medical Service.

Because of the particular interest in wartime problems and treatments this year, Dr. Schmidt has developed a symposium on hemorrhage at which papers on "The Clinical Failure of Circulation—Hemorrhage and Shock," "Treatment—Clinical Failure of Circulation—Shock," and "The Treatment of Obstetrical Hemorrhage" will be presented.

Scientific Program

The Council on Scientific Work for the second consecutive year has delegated to Dr. Erwin R. Schmidt the task of developing the scientific program. The program this year is of unusual merit. Teachers, research men, and practicing physicians of unquestioned accomplishments have been secured to discuss their discoveries, experiences and knowledge with members attending the meeting. Twenty-seven out-of-state speakers and over forty members of the Society will participate in the program.



Erwin R. Schmidt

Out-of-state physicians who will appear on the scientific program are: A. R. Barnes, Rochester, Minn.; E. T. Bell, Minneapolis, Minn.; B. I. Beverly, Chicago, Ill.; M. L. Blatt, Chicago, Ill.; Wallace H. Cole, St. Paul, Minn.; Warren H. Cole, Chicago, Ill.; G. M. Curtis, Columbus, O.; H. P. Doub, Detroit, Mich.; G. P. Guibor, Chicago, Ill.; S. W. Harrington, Rochester, Minn.; E. A. Hines, Jr., Rochester, Minn.; H. P. Jenkins, Chicago, Ill.; Julius Jensen, St. Louis, Mo.; C. G. Loosli, Chicago, Ill.; H. O. McPheeters, Minneapolis, Minn.; I. H. Page, Indianapolis, Ind.; T. L. Pool, Rochester, Minn.; Lieutenant Colonel W. C. Porter, Washington, D. C.; F. W. Rankin, Lexington, Ky.; E. H. Rynearson, Rochester, Minn.; W. W. Scott, Chicago, Ill.; G. E. Shambaugh, Jr., Chicago, Ill.; T. D. Spies, Cincinnati, O.; W. W. Spink, Minneapolis, Minn.; O. E. Van Alyea, Chicago, Ill.; J. W. White, New York, N. Y.; and R. H. Woods, La Salle, Ill.

Sectional Meetings

The sectional meetings will be of special interest to those limiting their practice to one field of medicine. They will be presented on Wednesday, September 16, under the supervision of chairmen who have assembled subject matter of current special interest. Sectional chairmen who will serve this year are as follows:

Dr. G. Hoyme, Eau Claire—Section on Internal Medicine and Cardiology

Dr. F. M. Frechette, Janesville—Section on Obstetrics and Gynecology

Dr. R. O. Ebert, Oshkosh—Sections on Ophthalmology and Otolaryngology

Dr. W. P. Blount, Milwaukee—Section on Orthopedics

Dr. F. R. Janney, Wauwatosa—Section on Pediatrics

Dr. L. W. Paul, Madison—Section on Radiology

Dr. A. R. Tormey, Madison—Section on Surgery

Dr. A. H. Gundersen, La Crosse—Section on Urology

Scientific Exhibits

Visual means of education have forged their way into postgraduate medical teaching to recall to the physician his classroom work. In the scientific exhibits, physicians will again have an opportunity to smell the familiar odor of formaldehyde and recall their school dissecting periods, for the applied anatomy exhibits which proved so popular at the Centennial Meeting will again be presented by the Marquette University

A photograph from the collection of Dr. Howard J. Lee, Oshkosh, to be on display at Physicians' Hobby Show.

School of Medicine and the University of Wisconsin Medical School. For emphasis on the subject of anatomy, more material has been added to the basic anatomy exhibits presented at the Centennial Meeting.

In the Main Arena of the Milwaukee Auditorium will be Dr. Eben J. Carey's exhibit on "Experimental Ameboid Motion of Motor Nerve Plates," which was awarded the Gold Medal at the annual meeting of the American Medical Association. The exhibit of Dr. Norbert Enzer entitled "Investigations of Sensory and Motor Centers in Fatigue and Disease," also presented at the American Medical Association meeting, will be shown. A complete list of the scientific exhibits appears on page 701 of this issue of *The Journal.*

Motion Pictures

Scientific motion pictures will be used this year as another means of setting forth recent advances in medicine. Dr. H. Kent Tenney of Madison, who has familiarized himself with the subject of sound motion pictures, has arranged, at the request of the Council on Scientific Work, for the showing of these pictures two hours each day,—the first hour in the morning and the last hour in the afternoon.

H. Kent Tenney

Annual Dinner

By custom, the president of the Society selects the speaker for the annual dinner of the Society. This year Dr. Gunnar Gundersen has obtained Dr. F. W. Rankin, president of the American Medical Association, who will speak on "The Doctor's Part in the War Program." The dinner will be held in the newly air-conditioned Crystal Ballroom of the Hotel Schroeder at 6:45 p. m. Those at the speakers' table wear dinner dress, but other guests will wear either dinner clothes or business suits and street dresses.

Fred W. Rankin

House of Delegates

During recent years, complex problems facing organized medicine have necessitated the scheduling of increasingly longer sessions of the House of Delegates so that detailed and thorough discussion and study might be given to problems at hand. This year the Council and the Council on Scientific Work chose Monday, Tuesday and Wednesday for the scientific program so that the initial meeting of the House of Delegates might be held on Sunday afternoon. The time has been set tentatively for five o'clock. This change was made so that physicians might find it possible to attend meetings of the House of Delegates as well as the scientific sessions with a minimum loss of time from their offices.

The second factor which impelled this change was the increased demands made upon physicians at home through the induction of many members into military and naval service.

Notify your home and office that you can be reached at the Milwaukee Auditorium by calling Broadway 8030.

Physicians' Hobby Show

The first state-wide physicians' hobby exhibit has been developed under the direction of Dr. C. J. Smiles of Ashland. Exhibits of varied character from all parts of the state will be shown in the physicians' hobby hall. Noteworthy among the exhibits to be presented will be one on magic by Dr. E. T. Ackerman of Gays Mills, who will give sleight-of-hand and magic demonstrations during recess periods and at intervals during the meeting.

Clyde J. Smiles

Wild life specimens have recently been acquired for the physicians' hobby hall and will be shown by Dr. E. B. Pfefferkorn of Oshkosh. Other exhibits will include a display of a wide variety of firearms gathered by Dr. K. H. Doege, Marshfield, waterfowl photography by Dr. H. J. Lee, Oshkosh, an elaborate collection of bells by Dr. R. G. Arveson of Frederic, a collection of glassware, stamps, colored flower motion pictures and kodachrome colored prints.

REPORTS OF OFFICERS AND COMMITTEES TO APPEAR IN SEPTEMBER JOURNAL

Because of the fact that the secretary's office has been carrying an extra heavy burden of correspondence in connection with the war effort, it has been necessary to delay the preparation and publication of reports of officers and committees. These reports customarily appear in the August issue of *The Journal;* however, so that sufficient time may be allowed for compiling complete reports, they will not be published until September.

Members of the House of Delegates will be sent page proof in advance of the annual meeting so that they may have time for review and consideration of the reports prior to the first meeting of the House.

Meeting High Lights

SUNDAY, SEPTEMBER 13 . . .

P. M.
5:00 House of Delegates—Banquet Room (Fifth Floor), Hotel Schroeder

MONDAY, SEPTEMBER 14 . . .

A. M.
7:30 Registration—Main Arena, Milwaukee Auditorium
8:00 Scientific Motion Pictures—Plankinton Hall, Milwaukee Auditorium
9:00 General Session—Plankinton Hall, Milwaukee Auditorium
10:00 Recess to View Exhibits
10:30 General Session—Plankinton Hall, Milwaukee Auditorium

P. M.
12:10 Round-Table Luncheons—Hotel Schroeder
2:00 General Session—Plankinton Hall, Milwaukee Auditorium
3:00 Recess to View Exhibits
3:30 General Session—Plankinton Hall, Milwaukee Auditorium
6:45 House of Delegates—Pere Marquette Room (Fifth Floor), Hotel Schroeder
8:30 Smoker—Crystal Ballroom (Fifth Floor), Hotel Schroeder

TUESDAY, SEPTEMBER 15 . . .

A. M.
8:00 House of Delegates—Banquet Room (Fifth Floor), Hotel Schroeder
Scientific Motion Pictures—Plankinton Hall, Milwaukee Auditorium
9:00 General Session—Plankinton Hall, Milwaukee Auditorium
10:00 Recess to View Exhibits
10:30 General Session—Plankinton Hall, Milwaukee Auditorium

P. M.
12:10 Round-Table Luncheons—Hotel Schroeder
2:00 General Session—Plankinton Hall, Milwaukee Auditorium
3:00 Recess to View Exhibits
3:30 General Session—Plankinton Hall, Milwaukee Auditorium
6:45 Annual Dinner—Crystal Ballroom, Hotel Schroeder

WEDNESDAY, SEPTEMBER 16 . . .

A. M.
8:00 Scientific Motion Pictures—Plankinton Hall, Milwaukee Auditorium
9:00 Section on Internal Medicine and Cardiology—Plankinton Hall, Milwaukee Auditorium
Section on Obstetrics and Gynecology—Walker Hall, Milwaukee Auditorium
Section on Ophthalmology—Juneau Hall, Milwaukee Auditorium
Section on Orthopedics—North Kilbourn Hall, Milwaukee Auditorium
Section on Pediatrics—South Kilbourn Hall, Milwaukee Auditorium
Section on Radiology—Committee Room D, Milwaukee Auditorium
Section on Surgery—Engelmann Hall, Milwaukee Auditorium
Section on Urology—Committee Room A, Milwaukee Auditorium

P. M.
12:10 Round-Table Luncheons—Hotel Schroeder
2:00 General Session—Plankinton Hall, Milwaukee Auditorium
Section on Otolaryngology—Juneau Hall, Milwaukee Auditorium

OUR GUEST SPEAKERS

Dr. Arlie R. Barnes
Professor of Medicine,
University of Minnesota
Graduate School,
Minneapolis;
The Mayo Clinic,
Rochester, Minnesota

Dr. Stuart W. Harrington
Professor of Surgery,
University of Minnesota
Graduate School,
Minneapolis;
The Mayo Clinic,
Rochester, Minnesota

Walter J. Meek, Ph. D.
Acting Dean and
Professor of Physiology,
University of Wisconsin
Medical School,
Madison, Wisconsin

SUNDAY EVENING, SEPTEMBER 13 . . .

5:00 House of Delegates
Banquet Room (Fifth Floor), Hotel Schroeder

MONDAY MORNING, SEPTEMBER 14 . . .

7:30 Registration
Main Arena, Milwaukee Auditorium

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Diagnosis of Early Syphilis
Diagnosis of Late Syphilis
Management of Syphilis

Symposium on the Heart

9:00 Physiology of Heart and Circulation
Walter J. Meek, Ph.D., acting dean and professor of physiology, University of Wisconsin Medical School, Madison

9:20 Physiologic Principles in Cardiac Diagnosis
Vincent Koch, Janesville

9:40 Diagnosis of Pathologic Conditions of the Heart
Arlie R. Barnes, professor of medicine, University of Minnesota Graduate School, Minneapolis–Rochester; Mayo Clinic, Rochester, Minnesota

10:00 Recess to view exhibits

This time is set aside to give you an opportunity to visit the technical and scientific exhibits. Please stop in and see them.

10:30 Treatment of Cardiac Emergencies in the Home
Francis D. Murphy, clinical professor of medicine, Marquette University School of Medicine, Milwaukee

10:50 Cardiac Treatment at the Hospital
A. G. Koehler, Oshkosh

11:10 Constricting Pericarditis
S. W. Harrington, professor of surgery, University of Minnesota Graduate School, Minneapolis–Rochester; Mayo Clinic, Rochester, Minnesota

11:30 Procurement and Assignment Service
R. E. Fitzgerald, state chairman of Procurement and Assignment Service, Milwaukee

MONDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. Treatment of Painful Feet—How to Meet the Problem
   Robert P. Montgomery, Milwaukee
2. Wisconsin Procurement and Assignment Service
   Announcement of round-table leader and other details will be contained in a special bulletin to members on round-table luncheons.
3. Medical Participation in Civilian Defense
   Announcement of round-table leader and other details will be contained in a special bulletin to members on round-table luncheons.
4. Bedside Medicine and Newer Drugs
   O. O. Meyer, associate professor of medicine, University of Wisconsin Medical School, Madison
5. Cardiac Emergencies in the Home
   Chester M. Kurtz, assistant professor of medicine, University of Wisconsin Medical School, Madison
6. Amputations and Artificial Limbs
   John O. Dieterle, Milwaukee
7. Blood Transfusions and Blood Banks
   W. D. Stovall, professor of hygiene, University of Wisconsin Medical School, Madison
8. What About Vaccines and the Prevention of Common Colds?
   Thomas O. Nuzum, Janesville
9. Medical Management of Ulcers of the Stomach
   Frederick W. Madison, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee
10. Refractions in the General Office
    Ferdinand H. Haessler, Milwaukee
11. Bedside Medicine and Newer Drugs
    Francis D. Murphy, Milwaukee
12. The Cardiac Problems of the General Practitioner
    Arlie R. Barnes, Rochester, Minnesota
13. What To Do About Prolonged Labor
    Carl S. Harper, assistant clinical professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison
14. Toxemia in Pregnancy
    Chairman to be announced later
15. Treatment of Skin Diseases in General Practice
    Stephan Epstein, Marshfield
16. Surgical Measures in Tuberculosis
    a. A. R. Curreri, assistant professor of surgery, University of Wisconsin Medical School (chairman), Madison
    b. W. H. Oatway, Jr., assistant professor of medicine, University of Wisconsin Medical School, Madison
17. Newer Therapy in Poliomyelitis
    a. Herman Wirka, associate professor of orthopedic surgery, University of Wisconsin Medical School (chairman), Madison
    b. Kenneth McDonough, assistant professor of pediatrics, University of Wisconsin Medical School, Madison
18. The Use of Drugs in the Treatment of Skin Diseases
    Harry Foerster, assistant professor of dermatology, University of Wisconsin Medical School, Madison, and assistant clinical professor of dermatology, Marquette University School of Medicine, Milwaukee
19. Management of Gangrene of the Extremities
    R. T. Cooksey, Madison
20. Medical Problems of the Local Health Officer
    C. A. Harper, state health officer, Madison

Part of a collection of bells to be exhibited by Dr. R. G. Arveson (past-president and councilor, tenth district) in the Hobby Show at the One Hundred First Anniversary Meeting. Shaft bells in foreground were presented to Dr. F. G. Johnson, Sr., Iron River (councilor, eleventh district), by Mrs. Johnson on Christmas, 1893.

MONDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

Symposium on Hemorrhage

2:00 Pathologic Physiology of Hemorrhage
Frederick W. Madison, Milwaukee

2:20 Clinical Failure of Circulation—Hemorrhage and Shock
J. S. Supernaw, Madison

2:40 Treatment—Clinical Failure of Circulation—Shock
Conde F. Conroy, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee

3:00 Recess to view exhibits

> Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

3:30 The Treatment of Obstetrical Hemorrhage
Joseph M. Freeman, Wausau

3:50 The Treatment of Traumatic Hemorrhage
Arthur C. Taylor, Appleton

4:10 The Management of Nontraumatic Hemorrhage
W. A. Killins, Green Bay

4:30 Scientific motion pictures
Otoscopy in the Inflammations

MONDAY EVENING . . .

6:45 House of Delegates
Pere Marquette Room (Fifth Floor), Hotel Schroeder

8:30 Smoker
Crystal Ballroom (Fifth Floor), Hotel Schroeder

OUR GUEST SPEAKERS

Dr. Edward H. Rynearson
Assistant Professor of Medicine,
University of Minnesota Graduate School,
Minneapolis;
The Mayo Clinic,
Rochester, Minnesota

Dr. Wesley W. Spink
Associate Professor of Internal Medicine,
University of Minnesota Medical School;
Assistant Professor of Medicine,
University of Minnesota Graduate School,
Minneapolis, Minnesota

Dr. Tom D. Spies
Associate Professor of Medicine,
University of Cincinnati College of Medicine,
Cincinnati, Ohio

Dr. Clayton G. Loosli
Assistant Professor of Medicine
University of Chicago School of Medicine,
Chicago, Illinois

TUESDAY MORNING, SEPTEMBER 15 . . .

8:00 House of Delegates
Banquet Room (Fifth Floor), Hotel Schroeder

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Appendicitis in Children

Symposium on Sulfonamides

9:00 The Pharmacology of Sulfonamides
Harry Beckman, professor and director, department of pharmacology, Marquette University School of Medicine, Milwaukee

9:20 Sulfonamides in General Practice
Charles E. Pechous, Kenosha

9:40 Sulfonamides in Surgery
Frank D. Weeks, Ashland

10:00 Recess to view exhibits

> The technical exhibits make it possible to present the annual meeting without a registration fee. Express your appreciation to the exhibitors by visiting their booths.

10:30 Reports of officers

10:50 Address of Dr. Francis E. Butler, Menominee, incoming president

11:10 The Clinical Applications and Complications of the Sulfonamides
Wesley W. Spink, associate professor of internal medicine, University of Minnesota Medical School, Minneapolis; assistant professor of medicine, University of Minnesota Graduate School, Minneapolis

11:30 Recess to view exhibits

TUESDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. Bedside Medicine and Newer Drugs
   O. O. Meyer, Madison
2. The Management of Occiput Posteriors
   E. F. Schneiders, Madison
3. Early Lesions of the Breast
   Carl Eberbach, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee
4. Toxemias of Pregnancies
   Henry J. Olson, assistant clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee
5. Endocrines in Gynecology
   John E. Haberland, Milwaukee
6. Medical Management of Gallbladder Disease
   a. Harold E. Marsh (chairman), Madison
   b. Wesley W. Spink, Minneapolis
7. Pneumonia and Its Therapy
   a. Frederick W. Madison (chairman), Milwaukee
   b. Clayton G. Loosli, assistant professor of medicine, University of Chicago School of Medicine, Chicago
8. The Practical Use of Hormones
   E. H. Rynearson, assistant professor of medicine, University of Minnesota Graduate School, Minneapolis–Rochester; Mayo Clinic, Rochester, Minnesota
9. Everyday Facts about Vitamins
   Elmer L. Sevringhaus, professor of medicine, University of Wisconsin Medical School, Madison
10. Surgery of the Colon
    Joseph M. King, Milwaukee
11. Toxoid Immunization for Tetanus
    John E. Gonce, professor of pediatrics, University of Wisconsin Medical School, Madison
12. Sulfonamides in Genito-Urinary Surgery
    a. Ira R. Sisk, professor of urology, University of Wisconsin Medical School (chairman), Madison
    b. W. G. Sexton, Marshfield
    c. Alf H. Gundersen, La Crosse
13. Infant Feeding
    F. R. Janney, assistant clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee; Wauwatosa
14. Roentgenology of Spinal Fractures
    a. John E. Habbe, assistant clinical professor of roentgenology, Marquette University School of Medicine (chairman), Milwaukee
    b. L. W. Paul, associate professor of radiology, University of Wisconsin Medical School, Madison
15. Fractures of the Arm
    Herman C. Schumm, associate professor of orthopedic surgery, University of Wisconsin Medical School, Madison, and clinical professor of orthopedic surgery, Marquette University School of Medicine, Milwaukee
16. Estimation of Disability in Compensation Cases
    a. Chester C. Schneider (chairman), Milwaukee
    b. Mr. Harry A. Nelson, director, Workmen's Compensation, Industrial Commission, Madison
17. Management of Epilepsy
    Theodore C. Erickson, associate professor of surgery, University of Wisconsin Medical School, Madison
18. Neurology and Everyday Diagnosis
    a. John L. Garvey, clinical professor of neurology, Marquette University School of Medicine (chairman), Milwaukee
    b. Mabel G. Masten, associate professor of neurology and psychiatry, University of Wisconsin Medical School, Madison
19. Wisconsin Procurement and Assignment Service
    Details will be contained in a special bulletin to members on round-table luncheons.
20. Medical Participation in Civilian Defense
    Details will be contained in a special bulletin to members on round-table luncheons.
21. Fractures of Wrist, Humerus, and Ankle
    a. H. Louis Greene (chairman), Madison
    b. J. T. F. Gallagher, Madison
22. Surgery of the Stomach
    F. Gregory Connell, Oshkosh
23. Bedside Medicine and Newer Drugs
    Francis D. Murphy, Milwaukee

TUESDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

2:00 Pneumonia and Chemotherapy
Clayton G. Loosli, Chicago

2:20 The New Prophylactic Measures in Tetanus
Carl N. Neupert, assistant state health officer, Madison

2:40 Resuscitation of the Newborn Infant
William C. Keettel, special postgraduate instructor and adviser in obstetrics and gynecology, State Board of Health, Madison

3:00 Recess to view exhibits

Take this time to visit the technical, scientific and hobby exhibits. The exhibitors will appreciate seeing you.

3:30 Intra-Abdominal Diverticulitis
J. J. Gramling, Jr., Milwaukee

3:50 Actual Clinical Disturbances of the Endocrine Glands
E. H. Rynearson, Rochester, Minnesota

4:10 Advances in Vitamin Therapy
Tom D. Spies, associate professor of medicine, University of Cincinnati College of Medicine, Cincinnati

4:30 Scientific Motion Pictures
Treatment of Breech Presentation

6:45 Annual Dinner—Crystal Ballroom Hotel Schroeder—(Informal)
Speaker—Fred W. Rankin, president of the American Medical Association, Lexington, Ky.

WEDNESDAY MORNING MOTION PICTURE PROGRAM

The scientific motion pictures listed below have been selected particularly by Dr. H. Kent Tenney and the Council on Scientific Work for display in connection with the scientific sections.

8:00

Skin Graft—Plankinton Hall
The above motion picture will be of special interest to the Section on Surgery.

Abdominal Pelvic Operation for Residues of Infection—Walker Hall
Of special interest to the Section on Obstetrics and Gynecology.

First Aid in Transportation of Fractures of Arm, Leg and Spine—North Kilbourn Hall
Of interest to general surgeons, orthopedists and general practitioners.

8:30

Proctoscopic Cinematography — Plankinton Hall
For those interested in surgery.

Erythroblastic Anemia — South Kilbourn Hall
Of special interest to the Section on Pediatrics.

Emergency Traction for Safe Transportation of Fractures of the Long Bones —North Kilbourn Hall
For those interested in orthopedics or general surgery.

Hypospadias — Surgical Treatment of the Inlaying Graft Method—Walker Hall
Of particular interest to urologists and surgeons.

Dermatoses of Industrial Workers — Engelmann Hall
For dermatologists, internists and industrial surgeons.

WEDNESDAY MORNING, SEPTEMBER 16 . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00–9:00 Scientific Motion Pictures
Skin Graft
Proctoscopic Cinematography

SECTION ON INTERNAL MEDICINE AND CARDIOLOGY . . .

Dr. Elexious T. Bell

Professor of Pathology, University of Minnesota Medical School, and University of Minnesota Graduate School, Minneapolis, Minnesota

Dr. Edgar A. Hines, Jr.

Assistant Professor of Medicine, University of Minnesota Graduate School, Minneapolis; The Mayo Clinic, Rochester, Minnesota

See schedule of scientific motion pictures on page 690.

Chairman: G. Hoyme, Eau Claire

Plankinton Hall, Milwaukee Auditorium

Symposium on Hypertension

9:00 The Range of Blood Pressure and Hereditary Factors in Normal and Hypertensive States

E. A. Hines, Jr., assistant professor of medicine, University of Minnesota Graduate School, Minneapolis–Rochester; Mayo Clinic, Rochester, Minnesota

9:30 Blood Pressure in Life Insurance

D. E. W. Wenstrand, medical director, Northwestern Mutual Life Insurance Company, Milwaukee

10:00 Recess to view exhibits

Take this time to visit the technical, scientific and hobby exhibits. The exhibitors will appreciate seeing you.

10:30 The Pathology of Hypertension

E. T. Bell, professor of pathology, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis

Dr. Irvine H. Page

Indianapolis, Indiana

10:50 The Mechanism and Experimental Treatment of Hypertension

Irvine H. Page, Indianapolis

11:10 Summary of Facts and Treatment of Hypertension

Francis D. Murphy, Milwaukee

11:30 Recess to view exhibits

The hobby show is located in the main arena. Be sure and see it and the technical and scientific exhibits.

WEDNESDAY MORNING, SEPTEMBER 16 . . .

SECTION ON OBSTETRICS AND GYNECOLOGY . . .

Dr. Julius Jensen
Assistant Professor of Clinical Medicine, Washington University School of Medicine, St. Louis, Missouri

See schedule of scientific motion pictures on page 690.

Chairman: Francis M. Frechette, Janesville
Walker Hall, Milwaukee Auditorium

9:00 Implantation of a New Pituitary Gonadotropic Hormone with Results in a Series of Cases
John Dale Owen, clinical instructor in obstetrics and gynecology, Marquette University School of Medicine, Milwaukee
Discussant:
9:20 J. W. Lambert, Antigo

9:30 The Use of Sulfonamides in Obstetrics
D. M. Gallaher, Appleton
Discussant:
9:50 Woodruff Smith, Ladysmith

10:00 Recess **to view exhibits**

Take this time to visit the technical, scientific and hobby exhibits. The exhibitors will appreciate seeing you.

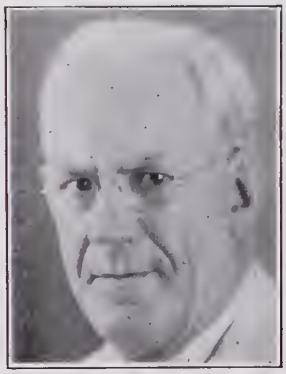
10:30 The Management of Toxemia in the Last Trimester of Pregnancy
Warner S. Bump, Rhinelander
Discussant:
10:50 J. W. McGill, Superior

11:00 Modern Concepts of the Relation between Heart Disease and Pregnancy
Julius Jensen, assistant professor of clinical medicine, Washington University School of Medicine, St. Louis
Discussant:
11:20 Thomas O. Nuzum, Janesville

11:30 Recess to **view exhibits**

The hobby show is located in the main arena. Be sure and see it and the technical and scientific exhibits.

SECTION ON OPHTHALMOLOGY . . .



Dr. James W. White
Clinical Professor of Ophthalmology, New York Postgraduate Medical School, Columbia University, New York, New York

See schedule of scientific motion pictures on page 690.

Dr. George P. Guibor
Chicago, Illinois

Chairman: R. O. Ebert, Oshkosh
Juneau Hall, Milwaukee Auditorium

9:00 The Practical Use of Prisms
George P. Guibor, Chicago

Dr. Ralph H. Woods
La Salle, Illinois

Discussant:
9:20 Aubrey H. Pember, Janesville

9:30 Squint and Amblyopia
I. Franklin, Milwaukee
Discussant:
9:50 F. H. Haessler, Milwaukee

10:00 Recess to view exhibits

> The hobby show is located in the main arena. Be sure and see it and the technical and scientific exhibits.

10:30 Diagnosis in Diseases of Eye Muscles
James W. White, clinical professor of ophthalmology, New York Postgraduate Medical School, Columbia University, New York
Discussant:
10:50 E. J. Zeiss, Appleton

11:00 Frequent Causes of Eye Discomfort
Ralph H. Woods, La Salle, Illinois
Discussant:
11:20 Leopold J. Friend, Beloit

11:30 Recess to view exhibits

> Take this time to visit the technical, scientific and hobby exhibits. The exhibitors will appreciate seeing you.

SECTION ON ORTHOPEDICS . . .

> See schedule of scientific motion pictures on page 690.

Chairman: Walter P. Blount, Milwaukee
North Kilbourn Hall, Milwaukee Auditorium

9:00 The Treatment of Painful Feet in General Practice
Robert P. Montgomery, Milwaukee
Discussants:
9:20 David J. Ansfield, Milwaukee
Charles M. Ihle, Eau Claire

9:30 The Modern Treatment of Acute Osteomyelitis
A. C. Schmidt, Milwaukee
Discussants:
9:50 John O. Dieterle, Milwaukee
Lemuel D. Smith, Milwaukee

10:00 Recess to view exhibits

> The hobby show is located in the main arena. Be sure and see it and the technical and scientific exhibits.

10:30 The Kenny Treatment of Anterior Poliomyelitis
Wallace H. Cole, professor of surgery and director of division of orthopedic surgery, University of Minnesota Medical School, and University of Minnesota Graduate School, Minneapolis
Discussants:
10:50 Walter P. Blount, Milwaukee
Robert E. Burns, professor of orthopedic surgery, University of Wisconsin Medical School, Madison

11:00 Reconstruction Surgery for the Sequelae of Anterior Poliomyelitis
Herman Wirka, Madison
Discussants:
11:20 Herman C. Schumm, Milwaukee
H. Louis Greene, Madison

11:30 Recess to view exhibits

> Take this time to visit the technical, scientific and hobby exhibits. The exhibitors will appreciate seeing you.

LIBRARY OF THE
COLLEGE OF PHYSICIA
OF PHILADELPHIA

WEDNESDAY MORNING, SEPTEMBER 16 . . .

SECTION ON PEDIATRICS . . .

Dr. Bert Beverly
Assistant Clinical Professor of Pediatrics, Rush Medical College, University of Chicago, Chicago, Illinois

Dr. Maurice Blatt
Professor of Pediatrics, University of Illinois College of Medicine, Chicago, Illinois

See schedule of scientific motion pictures on page 690.

Chairman: F. R. Janney, assistant clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee; Wauwatosa

South Kilbourn Hall, Milwaukee Auditorium

9:00 Recent Advances in the Treatment of Meningitis
V. J. Cordes, Wauwatosa
Discussants:
9:20 Henry Sincock, Superior
John E. Gonce, Madison

9:30 Electroencephalography in Pediatrics
M. G. Peterman, Milwaukee
Discussants:
9:50 Hans W. Hefke, Milwaukee
Theodore C. Erickson, Madison

10:00 Recess to view exhibits

The hobby show is located in the main arena. Be sure and see it and the technical and scientific exhibits.

10:30 Control of Contagion in Childhood
Maurice Blatt, professor of pediatrics, University of Illinois College of Medicine, Chicago
Discussants:
10:50 R. P. Schowalter, assistant clinical professor of medicine, Marquette University School of Medicine, Milwaukee
E. R. Krumbiegel, city health commissioner, Milwaukee

11:00 Emotional States and Management Problems in Childhood
Bert Beverly, assistant clinical professor of pediatrics, Rush Medical College, University of Chicago, Chicago
Discussants:
11:20 Eugenia S. Cameron, State Board of Health, Madison
H. Kent Tenney, associate professor of pediatrics, University of Wisconsin Medical School, Madison

11:30 Recess to view exhibits

Don't fail to see the fine display of technical, scientific and hobby exhibits in the main arena.

EXHIBITS IN MAIN ARENA

All of the facilities of the Milwaukee Auditorium will be devoted to exhibits of a varied character,—scientific, technical, hobby and wartime exhibits. This means of postgraduate medical education has demonstrated its effectiveness.

The technical exhibits make possible your attendance at the One Hundred First Anniversary Meeting without payment of a registration fee. If it were not for these exhibitors, it would be necessary to charge a minimum registration fee of from $4 to $5. All of the exhibitors have a genuine message for you. You will be well repaid if you will stop at their booths.

SECTION ON RADIOLOGY . . .

Dr. Howard P. Doub
Detroit, Michigan

See schedule of scientific motion pictures on page 690.

Chairman: L. W. Paul, associate professor of radiology, University of Wisconsin Medical School, Madison

Committee Room D, Milwaukee Auditorium

9:00 Case Reports
H. W. Hefke, Milwaukee
W. T. Clark, Janesville
Theodore Sokow, Kenosha
L. V. Littig, Madison
T. J. Pfeffer, Racine
I. G. Ellis, Madison
R. P. Potter, Marshfield

10:00 Recess to view exhibits

Don't fail to see the fine display of technical, scientific and hobby exhibits in the main arena.

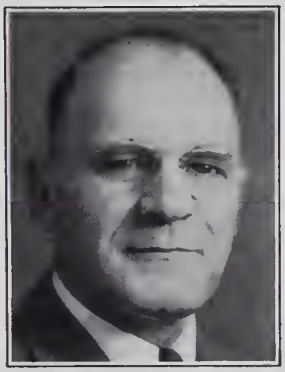
10:30 A Technic for Iodized Oil Myelography
S. A. Morton, Milwaukee
Discussants:
10:50 E. E. Seedorf, La Crosse
L. V. Littig, Madison

11:00 The Roentgenographic Changes in Virus Pneumonia
Howard P. Doub, Henry Ford Hospital, Detroit
Discussants:
11:20 R. P. Potter, Marshfield
S. R. Beatty, Oshkosh

11:30 Recess to view exhibits

SECTION ON SURGERY . . .

Dr. Hilger P. Jenkins
Associate Professor of Surgery,
University of Chicago,
The School of Medicine,
Chicago, Illinois



Dr. Herman O. McPheeters
Minneapolis, Minnesota

See schedule of scientific motion pictures on page 690.

Chairman: Albert Tormey, Madison

Engelmann Hall, Milwaukee Auditorium

9:00 Appendicitis: Thirty-Five Year Survey in Rock County
W. A. Munn, Janesville
T. J. Snodgrass, Janesville
T. H. Flarity, Beloit
Discussants:
9:20 Paul F. Doege, Marshfield
M. H. Wirig, Madison

9:30 Problems in the Selection, Preparation, and Use of Suture Material in General Surgery
Hilger P. Jenkins, associate professor of surgery, University of Chicago, School of Medicine, Chicago
Discussants:
9:50 Nels Werner, Eau Claire
William J. Tucker, Ashland

WEDNESDAY MORNING, SEPTEMBER 16 . . .

10:00 Recess to view exhibits

> Don't fail to see the fine display of technical, scientific and hobby exhibits in the main arena.

10:30 Cesarean Section
Roland S. Cron, clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee
Discussants:
10:50 William C. Keettel, Madison
E. F. Schneiders, Madison

11:00 The Present Day Treatment of Varicose Veins
H. O. McPheeters, Minneapolis
Discussants:
11:20 George G. Stebbins, Madison
Matthew A. McGarty, La Crosse

11:30 Recess to view exhibits

> The hobby show is located in the main arena. Be sure and see it and the technical and scientific exhibits.

SECTION ON UROLOGY . . .

Dr. Thomas L. Pool
Mayo Clinic,
Rochester, Minnesota

> See schedule of scientific motion pictures on page 690.

Chairman: Alf H. Gundersen, La Crosse
Committee Room A, Milwaukee Auditorium

9:00 Present Day Status of Hormonal Treatment for Urologic Conditions
Walter M. Kearns, Milwaukee
Discussant:
9:20 George Ewell, Madison

9:30 Castration Treatment of Carcinoma of the Prostate
W. W. Scott, Chicago
Discussant:
9:50 Charles Marquardt, assistant clinical professor of urology, Marquette University School of Medicine, Milwaukee

10:00 Recess to view exhibits

> Don't fail to see the fine display of technical, scientific and hobby exhibits in the main arena.

10:30 The Treatment of Urinary Tract Infections with the Sulfonamide Group of Drugs
T. L. Pool, Mayo Clinic, Rochester, Minnesota
Discussant:
10:50 H. M. Stang, Eau Claire

11:00 Report of Prostatic Surgery at the Wisconsin General Hospital in 1940–1941
Ira R. Sisk, Madison
Discussant:
11:20 Alexander D. Spooner, Milwaukee

11:30 Recess to view exhibits

> Be sure to visit the Procurement and Assignment Service booth on the stage in the main arena of the Milwaukee Auditorium.

TELEPHONE SERVICE AT AUDITORIUM

Your telephone number at the Milwaukee Auditorium will be Broadway 8030. When you leave to attend sessions of the One Hundred First Anniversary Meeting, leave word at your home and office that you can be reached at that number.

WEDNESDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. Cardiac Risks in Obstetrics
   Julius Jensen, St. Louis
2. Sutures in Surgery
   Hilger P. Jenkins, Chicago
3. Injection of Varicose Veins
   H. O. McPheeters, Minneapolis
4. Cesarean Section
   Roland Cron, Milwaukee
5. Orthopedics in Children
   a. Walter P. Blount (chairman), Milwaukee
   b. Wallace H. Cole, St. Paul
6. Control of Contagion in Childhood
   Maurice Blatt, Chicago
7. Title to be announced later
8. The Roentgenographic Aspects of Diseases Affecting the Spinal and Intervertebral Discs
   H. P. Doub, Detroit
9. The Mechanism and Experimental Treatment of Hypertension
   Irvine H. Page, Indianapolis
10. The Etiology of Primary Hypertension
    E. T. Bell, Minneapolis
11. The Prevention and Treatment of Thrombosis and Embolism
    E. A. Hines, Jr., Rochester, Minnesota
12. Mutual Problems in Life Insurance Examinations
    D. E. W. Wenstrand, Milwaukee
13. Carcinoma of the Prostate
    W. W. Scott, Chicago
14. Sinusitis and Its Management
    O. E. Van Alyea, Chicago
15. Recent Advances in Human Blood Typing
    a. Norbert Enzer (chairman), Milwaukee
    b. I. Davidsohn, Chicago
    sponsored by the Wisconsin Society of Pathologists
16. Wisconsin Procurement and Assignment Service
    Announcement of round-table leader and other details will be contained in a special bulletin to members on round-table luncheons
17. Medical Participation in Civilian Defense
    Announcement of round-table leader and other details will be contained in a special bulletin to members on round-table luncheons
18. Rheumatism
    a. Milton C. Borman (chairman), Milwaukee
    b. Vincent Koch, Janesville
19. Drugs in Skin Diseases
    Harry R. Foerster, Milwaukee
20. Management of Occiput Posteriors
    Benjamin E. Urdan, assistant clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee
21. Hospital Administration and Practice of Medicine
    Harry W. Sargeant, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee; Milwaukee County Hospital, Wauwatosa
22. Surgical Emergencies
    Albert Tormey, Madison
23. Past-Presidents' Luncheon

A portion of the taxidermy exhibit on wild life to be shown in the Hobby Show by Dr. E. B. Pfefferkorn, Oshkosh.

WEDNESDAY AFTERNOON . . .

GENERAL SESSION . . .

Dr. Warren H. Cole
Professor of Surgery,
University of Illinois
College of Medicine,
Chicago, Illinois

Dr. George M. Curtis
Professor of Surgery,
Ohio State University,
College of Medicine,
Columbus, Ohio

Plankinton Hall, Milwaukee Auditorium

2:00 Theresa Rogers Memorial Lecture—War and Neuropsychiatry
Lt. Col. William C. Porter, Medical Corps, U. S. Army, Walter Reed General Hospital, Washington, D. C.

2:30 Blast Injuries
George M. Curtis, professor of surgery, department of research surgery, Ohio State University College of Medicine, Columbus, Ohio

3:00 The Treatment of Civilian War Injuries
Warren H. Cole, professor of surgery, University of Illinois College of Medicine, Chicago

Lieutenant Colonel
William C. Porter
Medical Corps, U.S. Army
Walter Reed General
Hospital
Washington, D. C.

THE WAR EXHIBITS

On the stage in the Main Arena of the Milwaukee Auditorium will be an extensive exhibit prepared by the Procurement and Assignment Service in which its work will be portrayed and an opportunity given to members of the Society to obtain authentic information concerning enlistment in the armed forces.

In addition, there will be a booth devoted to Emergency Medical Service, presented under the joint supervision of Dr. John S. Coulter, Chicago, regional medical officer for the Sixth Civilian Defense Region, and Dr. R. E. Fitzgerald, Milwaukee, state chief of Emergency Medical Service. In this exhibit, members may become familiar with the odors of various gases used in warfare through the "sniff test." Gas masks and clothing will be displayed and technical information will be given on the effect of war gases on the human body.

Medical supplies and equipment outlined in Medical Division Bulletin #2 of the Office of Civilian Defense will be displayed, and the exhibit will include first-aid post units, casualty station units, stretcher insert racks, Thomas splints and similar facilities. A special section of the booth will be devoted to the Wisconsin Nursing Council for War Service and Miss Mildred Fehlhauer, nurse deputy to the state chief of Emergency Medical Service, will be in charge.

SECTION ON OTOLARYNGOLOGY . . .

Dr. George E. Shambaugh, Jr.
Associate Clinical Professor of Laryngology and Otolaryngology, Rush Medical College, University of Chicago
Chicago, Illinois

Dr. Oliver E. Van Alyea
Chicago, Illinois

Chairman: R. O. Ebert, Oshkosh
Juneau Hall, Milwaukee Auditorium

2:00 Sulfonamides in Eye, Ear, Nose and Throat
James W. Tanner, Eau Claire
Discussant:
2:20 R. C. Lowe, Neenah

2:30 Plastic Surgery of the Head
Volney B. Hyslop, professor of oral and plastic surgery, University of Wisconsin Medical School, Madison
Discussant:
2:50 G. V. I. Brown, emeritus professor of plastic surgery, University of Wisconsin Medical School, Madison; Milwaukee

3:00 Recess to view exhibits

> The technical exhibits make it possible to present the annual meeting without a registration fee. Express your appreciation to the exhibitors by visiting their booths.

3:30 Allergy in Office Eye, Ear, and Throat Practice
George E. Shambaugh, Jr., associate clinical professor of laryngology and otolaryngology, Rush Medical College, University of Chicago, Chicago
Discussant:
3:50 George L. McCormick, Marshfield

4:00 Treatment of Acute Infections of the Nose and Sinuses
O. E. Van Alyea, Chicago
Discussant:
4:20 Otis M. Wilson, Wausau

4:30 Indications for Bronchoscopy
John D. Steele, Milwaukee
Discussant:
4:50 A. V. Cadden, Wauwatosa

Members—1942 House of Delegates

Society	*Delegate*	*Alternate Delegate*
Ashland–Bayfield–Iron	R. O. Grigsby, Ashland	C. J. Smiles, Ashland
Barron–Washburn–Sawyer–Burnett	D. L. Dawson, Rice Lake	S. O. Lund, Cumberland
Brown–Kewaunee–Door	P. R. Minahan, Green Bay	W. W. Kelly, Green Bay
	O. A. Stiennon, Green Bay	W. E. Leaper, Green Bay
Calumet	F. P. Knauf, Kiel	N. J. Knauf, Chilton
Chippewa	A. J. Somers, Chippewa Falls	J. J. Sazama, Bloomer
Clark	M. C. Rosekrans, Neillsville	H. H. Christofferson, Colby
Columbia–Marquette–Adams	H. M. Caldwell, Columbus	L. V. McNamara, Montello
Crawford	C. A. Armstrong, Prairie du Chien	H. H. Kleinpell, Prairie du Chien
Dane	A. R. Tormey, Madison	S. A. McCormick, Madison
	H. E. Marsh, Madison	A. J. Boner, Madison
	Louis Fauerbach, Madison	L. R. Cole, Madison
	A. T. Smedal, Stoughton	N. A. Hill, Madison
Dodge	A. G. Hough, Beaver Dam	W. E. Bargholtz, Reeseville
Douglas	T. J. O'Leary, Superior	H. J. Orchard, Superior
Eau Claire–Dunn–Pepin	J. C. Baird, Eau Claire	R. N. Leasum, Osseo
Fond du Lac	D. J. Twohig, Fond du Lac	J. C. Devine, Fond du Lac

MEMBERS—1942 HOUSE OF DELEGATES (Continued)

Society	*Delegate*	*Alternate Delegate*
Forest	H. C. Marsh, Crandon	G. E. Carroll, Laona
Grant	E. H. Spiegelberg, Boscobel	J. H. Fowler, Lancaster
Green	F. J. Bongiorno, Albany	L. E. Creasy, Monroe
Green Lake–Waushara	J. A. Kelly, Green Lake	H. C. Koch, Berlin
Iowa	S. B. Marshall, Hollandale	H. M. Walker, Dodgeville
Jefferson	G. E. Eck, Lake Mills	O. F. Dierker, Watertown
Juneau	C. A. Vogel, Elroy	A. R. Kaufman, Mauston
Kenosha	G. C. Schulte, Kenosha	W. C. Stewart, Kenosha
La Crosse	F. A. Douglas, La Crosse	A. H. Gundersen, La Crosse
Lafayette	R. B. Quinn, Darlington	Not reported
Langlade	C. E. Zellmer, Antigo	W. P. Curran, Antigo
Lincoln	R. G. Baker, Tomahawk	F. C. Lane, Merrill
Manitowoc	E. C. Cary, Reedsville	T. H. Rees, Manitowoc
Marathon	J. F. Smith, Wausau	E. E. Flemming, Wausau
Marinette–Florence	A. T. Nadeau, Marinette	H. W. Haasl, Peshtigo
Milwaukee	J. W. Truitt, Milwaukee	L. J. Van Hecke, Milwaukee
	E. L. Bernhart, Milwaukee	H. J. Farrell, Milwaukee
	J. W. Smith, Milwaukee	J. P. Conway, Milwaukee
	E. J. Carey, Milwaukee	J. J. Pink, Milwaukee
	R. A. Toepfer, West Allis	Aaron Yaffe, Milwaukee
	D. F. Pierce, Hales Corners	J. R. Regan, Milwaukee
	S. M. Markson, Milwaukee	G. S. Flaherty, South Milwaukee
	J. C. Griffith, Milwaukee	U. E. Gebhard, Milwaukee
	C. R. Marquardt, Milwaukee	M. C. Borman, Milwaukee
	Charles Fidler, Milwaukee	B. P. Churchill, Milwaukee
	Irwin Schulz, Milwaukee	M. W. Sherwood, Milwaukee
	W. M. Kearns, Milwaukee	J. E. Mulsow, Milwaukee
	C. M. Echols, Milwaukee	C. F. Conroy, Milwaukee
	W. A. Ryan, Milwaukee	F. X. McCormick, Milwaukee
	Norbert Enzer, Milwaukee	C. C. Schneider, Milwaukee
	R. F. Purtell, Milwaukee	Benjamin Lieberman, Milwaukee
	R. E. Galasinski, Milwaukee	W. L. MacKedon, Milwaukee
Monroe	C. S. Phalen, Sparta	Not reported
Oconto	A. F. Slaney, Oconto	C. R. Kwapy, Oconto
Oneida–Vilas	W. S. Bump, Rhinelander	I. E. Schiek, Rhinelander
Outagamie	G. W. Carlson, Appleton	D. W. Curtin, Little Chute
Pierce–St. Croix	Chalmer Davee, River Falls	A. E. McMahon, Menomonie
Polk	L. O. Simenstad, Osceola	K. F. Johnson, Frederic
Portage	E. E. Kidder, Stevens Point	R. J. Stollenwerk, Stevens Point
Price–Taylor	J. D. Leahy, Park Falls	H. B. Norviel, Phillips
Racine	T. C. Hemmingsen, Racine	E. J. Schneller, Racine
Richland	George Parke, Sr., Viola	G. H. Benson, Richland Center
Rock	H. E. Kasten, Beloit	R. A. Thayer, Beloit
	W. A. Munn, Janesville	W. T. Clark, Janesville
Rusk	L. M. Lundmark, Ladysmith	W. F. O'Connor, Ladysmith
Sauk	A. C. Edwards, Baraboo	F. R. Winslow, Baraboo
Shawano	F. L. Litzen, Gresham	A. A. Cantwell, Shawano
Sheboygan	C. J. Weber, Sheboygan	A. C. Radloff, Plymouth
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Whitehall	Robert Krohn, Black River Falls
Vernon	W. M. Trowbridge, Whitehall	J. J. Rouse, Hillsboro
Walworth	E. D. Sorenson, Elkhorn	D. H. Jeffers, Lake Geneva
Washington–Ozaukee	J. G. Hoffmann, Hartford	O. J. Hurth, Cedarburg
Waukesha	J. C. Hassall, Oconomowoc	R. E. Davies, Waukesha
Waupaca	A. M. Christofferson, Waupaca	J. H. Murphy, Clintonville
Winnebago	R. A. Jensen, Menasha	A. G. Koehler, Oshkosh
Wood	K. H. Doege, Marshfield	F. X. Pomainville, Wis. Rapids
Section on Cardiology	A. W. Bryan, Madison	F. D. Murphy, Milwaukee
Section on Ophthalmology and Otolaryngology	J. K. Trumbo, Wausau	A. H. Pember, Janesville
Section on Orthopedics	H. L. Greene, Madison	R. P. Montgomery, Milwaukee
Section on Radiology	J. E. Habbe, Milwaukee	L. V. Littig, Madison

The House of Delegates will meet on three occasions during the course of the meeting. The first session will convene at 5:00 p. m., Sunday, September 13; the second at 6:45 p. m., Monday, September 14; and the final session at 8:00 a. m., Tuesday, September 15.

SCIENTIFIC EXHIBITS

The scientific exhibit section, arranged this year under the direction of Dr. C. J. Smiles, Ashland, has been enlarged to embrace an increased number of displays. Dr. Smiles has been particularly fortunate in securing the exhibit prepared by Dr. Eben J. Carey, dean of the Marquette University School of Medicine, Milwaukee. This exhibit, entitled "Experimental Ameboid Motion of Motor Nerve Plates," received the Gold Medal Award at the recent meeting of the American Medical Association in Atlantic City.

Below are set forth the titles of exhibits and names of those in charge. A complete description of each display will be given in the September issue of *The Journal.*

Applied Anatomy
Walter E. Sullivan, Ph.D., professor of anatomy, University of Wisconsin Medical School, Madison; and Walter Zeit, Ph.D., assistant professor of anatomy, Marquette University School of Medicine, Milwaukee

Bronchoscopy
Wellwood Nesbit, professor of otolaryngology, University of Wisconsin Medical School, Madison

Wheezing That Is Not Asthma
G. L. Waldbott, Detroit

Plastic Surgery
V. B. Hyslop, professor of oral and plastic surgery, University of Wisconsin Medical School, Madison

Health and Nutrition
State Medical Society of Wisconsin, Madison

The Use and Abuse of Barbiturates
American Medical Association, Chicago

Medical Literature
Medical Library Service, Madison

Fenestration Operation For the Improvement in Hearing in Otosclerosis
George Shambaugh, Jr., associate clinical professor of laryngology and otology, Rush Medical College, University of Chicago, Chicago

Applied Medical Art
G. H. Hansmann, and Mr. John Stringer, Jr., Milwaukee

Proctoscopic Slides
J. M. Garner, Winnetka, Ill. and J. Peerman Nesselrod, Evanston, Ill.

Cancer of the Breast
James A., Arnold S., and Russell Jackson, Madison

Dietary Deficiency Diseases
American Medical Association, Chicago

Treatment of Rheumatoid Arthritis
Wisconsin Rheumatism Association

Anatomy of the Heart
Walter Zeit, Ph.D., assistant professor of anatomy, Marquette University School of Medicine, Milwaukee

Obstetric Manikin Demonstrations
Wisconsin Society of Obstetrics and Gynecology

Early Diagnosis of Tuberculosis by Radiography
Wisconsin Anti-Tuberculosis Association

Radiographic Studies
Wisconsin Roentgen Ray Society

Automobile Drivers Clinic
Motor Vehicle Department, Madison

Treatment of Traumatic Injuries of the Face
G. B. New, professor of otolaryngology and rhinology, University of Minnesota Graduate School, Minneapolis–Rochester, and J. B. Erich, Mayo Clinic, Rochester

Central Nervous System Factors in Fatigue and Disease
Norbert Enzer, S. Blankstein and E. Simonson

Experimental Ameboid Motion of Motor Nerve Plates
Eben J. Carey, dean and professor of anatomy, Marquette University School of Medicine, and Mr. Leo Massopust, Marquette University School of Medicine, Milwaukee

Appendicitis in Rock County
Rock County Medical Society

Prevention of Contagion in Pediatric Wards with the Use of Human Serum and Plasma
L. H. Barenberg, David Greene, Walter Levy, and N. M. Greenstein, New York. This exhibit will be presented under the supervision of the Section on Pediatrics

Educational Literature
Wisconsin State Board of Health

Endocarditis and Libman–Sack Disease
Emanuel Libman, New York. This exhibit will be presented under the supervision of the Section on Cardiology

Calcified Nodular Disease of the Aortic Valve
A. H. Wells, S. H. Boyer, Jr., and R. L. Nelson, St. Luke's Hospital, Duluth, Minn.

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Milwaukee
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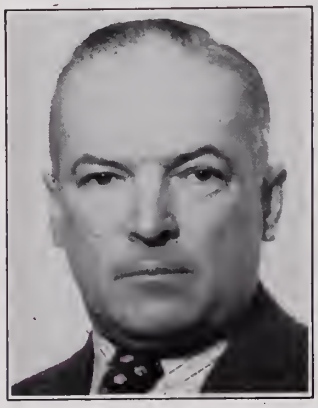

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Madison
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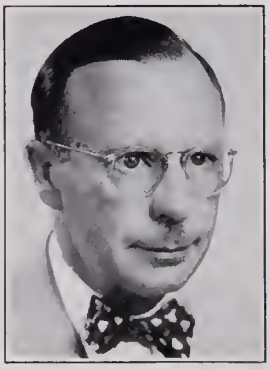

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R. P. SPROULE
Milwaukee
Past-President

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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Mrs. W. Homer Krehl, Madison
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Mrs. Charles Fidler, Milwaukee
Legislation (special committee)—
Mrs. H. Kent Tenney, Madison

Preliminary Program For Fourteenth Annual Meeting of Auxiliary

PLANS for the 1942 convention of the Woman's Auxiliary to the State Medical Society of Wisconsin have been made with a conscious effort to adhere as closely as possible to the programs of other years, in order that in this time of adjustment to the demands of the crisis, we might for a few days, at least, follow the procedure of more peaceful days and in the resulting relaxation gather new strength to return to the multiple tasks imposed upon us by the war. There is one innovation, the change of days for the meetings. You will notice that registration opens on Sunday instead of Tuesday. This change was made by the State Medical Society in order to cut to a minimum the number of days those physicians attending the convention would have to be absent from their offices.

Milwaukee is glad to have the convention back; we missed you all last year and are looking forward with real pleasure to seeing you in September. Along with the Milwaukee County Auxiliary, the Walworth and Kenosha County Auxiliaries are acting as hostesses. The Hotel Schroeder will again serve as headquarters for the convention, and registration will open there at two o'clock Sunday afternoon, September 13. Sunday evening the preconvention dinner meeting of the Board of Directors will be held at the Hotel Schroeder at seven o'clock. Monday morning the first business session will be held in the club rooms of the Schroeder at ten o'clock. At noon we shall enjoy a luncheon and style show planned by the Wal-

Mrs. R. D. Champney, Milwaukee
Convention Chairman

Mrs. J. S. Supernaw, Madison
President

worth County Auxiliary. In the evening while our husbands are attending the smoker we shall gather for a buffet supper and entertainment. Tuesday morning the second business session will be called to order at ten o'clock in the club rooms; this will be followed immediately by the post-convention meeting of the Board of Directors with the new president, Mrs. Ernest S. Schmidt, in the chair. Tuesday noon the Woman's Auxiliary to the Kenosha County Medical Society has planned a luncheon for us at the attractive club house of the Cudworth Post of the American Legion. After the luncheon there will be time for our guests to shop or go sightseeing before joining their husbands for the informal banquet to be held in the Crystal Ballroom of the Hotel Schroeder.

We sincerely hope as many convention visitors as possible will participate in our program. While the convention is planned BY the Auxiliary it is planned FOR all doctors' wives whether Auxiliary members or not. There are, however, certain things each Auxiliary member will want to bring with her to the annual meeting. These are intangibles which outweigh in importance all the tangible impedimenta we, as women, are prone to consider important when we assemble in groups. When we are considering the wardrobe with which we hope to make a favorable impression we should not forget that we can be more valuable if we bring with us enthusiasm, a willing spirit of co-operation, and some constructive ideas for extending the influence of the Auxiliary than if we stress material things. If we can contribute some ideas for public relations work or program planning, if we can point out some workable method for serving our communities in the way of health education, we shall be of real value to our organization. Since we are seizing these three days from lives crowded with war activity, it is our responsibility to justify our action, a simple thing to do if after participating actively in the discussion groups we return home with keener interest, new ideas, and concrete plans for extending the sphere of activity of the Auxiliary in our own communities. The program of the Woman's Auxiliary to the American Medical Association, of which we are a component part, has been planned with full consciousness of its responsibility to society. Unless each state assumes its share of this responsibility that program will fail; therefore, let us demonstrate our willingness to co-operate by making a special effort to derive all benefits possible from this meeting. Won't you all join us in Milwaukee on September 13, 14, 15 and by your presence and active participation make the fourteenth annual convention of the Woman's Auxiliary to the State Medical Society of Wisconsin a real success?

MANETTE CHAMPNEY
Convention Chairman

ALICE FITZGERALD
Publicity Chairman

PRELIMINARY PROGRAM

Sunday, September 13, 1942

P. M.

2:00–4:30 Registration—Hotel Schroeder

7:00 Board of Directors' Dinner—Hotel Schroeder
Mrs. J. S. Supernaw, president, presiding

Guests

Past-presidents, Woman's Auxiliary to the State Medical Society of Wisconsin

Wisconsin's three national officers: Mrs. Eben J. Carey, Wauwatosa, president-elect; Mrs. Robert E. Fitzgerald, Wauwatosa, parliamentarian; Mrs. George H. Ewell, Madison, editor of the Bulletin, press and publicity chairman

Monday, September 14, 1942

A. M.

10:00 General Meeting — Club Rooms, Hotel Schroeder
Mrs. J. S. Supernaw, president, presiding
Invocation
Convention Announcements
Address of Welcome and Response
In Memoriam
Reports of State Officers
Reports of County Auxiliary Presidents
Report of Chairman, Committee on Credentials and Registration
Announcements

P. M.

1:00 Luncheon—Hotel Schroeder
Hostesses—Members of the Woman's Auxiliary to the Walworth County Medical Society
Style Show—Fashions by Hixon's

7:00 Buffet Supper—Hotel Schroeder
Entertainment to be announced later

Tuesday, September 15, 1942

A. M.

10:00 General Meeting — Club Rooms, Hotel Schroeder
Mrs. J. S. Supernaw, president, presiding
Business Session
Election of Officers
Induction of the President, Mrs. Ernest S. Schmidt
Installation of New Officers
Announcements

11:30 Post-Convention Meeting—Board of Directors —Club Rooms, Hotel Schroeder
Mrs. Ernest S. Schmidt, president, presiding

P. M.

1:00 Luncheon — Cudworth Post of American Legion
Hostesses—Members of the Woman's Auxiliary to the Kenosha County Medical Society
Round-table groups in charge of state chairmen
Greetings from Dr. Gunnar Gundersen, president, State Medical Society of Wisconsin
Address—guest speaker

6:45 Informal Banquet, State Medical Society of Wisconsin — Crystal Ballroom, Hotel Schroeder

Annual Meeting Committee Chairmen*

Headquarters

Mrs. C. D. Partridge, Cudahy

Flowers

Mrs. V. L. Baker
Mrs. D. E. Wenstrand, co-chairman

Registration and Credentials

Mrs. E. J. Schelble
Mrs. R. P. Schowalter, co-chairman

Reservations

Mrs. G. J. Pugh
Mrs. R. C. Pfeil, co-chairman

* Unless otherwise indicated, committee members are from Milwaukee.

Mrs. E. S. Schmidt, Green Bay
President-elect

Publicity
Mrs. E. M. Lawler
Mrs. R. E. Fitzgerald, Wauwatosa, co-chairman

Convention Hall
Mrs. E. L. Everts
Mrs. R. H. Frederick, West Allis, co-chairman

Information
Mrs. W. F. Grotjan
Mrs. G. H. Friedman, co-chairman

Program
Mrs. P. A. Lee

Monday Luncheon
Mrs. W. M. Jermain
Mrs. J. J. Gramling, Jr., co-chairman
Mrs. E. F. Barta
Hostesses—Walworth County Auxiliary

Monday Supper
Mrs. T. M. Northey
Mrs. E. L. Bernhart, co-chairman

Tuesday Luncheon
Mrs. W. C. Liefert
Mrs. A. R. Langjahr, co-chairman
Hostesses—Kenosha County Auxiliary

Executive Committee
Mrs. R. D. Champney
Mrs. E. M. Lawler, co-chairman
Mrs. P. A. Lee, co-chairman

Annual Dinner One of Auxiliary's Major Functions

Fred W. Rankin

Dr. Fred W. Rankin, president of the American Medical Association, Lexington, Kentucky, has been obtained by Dr. Gunnar Gundersen, president of the State Society, as the speaker for the One Hundred First Anniversary dinner which will be held on Tuesday evening in the Crystal Ballroom of the Hotel Schroeder. His subject will be "The Doctor's Part in the War Program." Dinner will be served promptly at 6:45.

Each successive annual dinner has won for itself increased attendance through the program presented and entertainment offered. This year with the attention of the physicians' wives focused on participation in the country's war effort, the message which will be given by Dr. Rankin will be as keenly awaited by Auxiliary members as by physicians themselves.

Officers of the Auxiliary have emphasized for many years that this dinner is an informal affair and have pointed out that while those at the speakers' table wear formal attire by custom, other guests wear either dinner clothes or business suits and street dresses.

Auxiliary members are urged to have their husbands purchase their annual dinner tickets when they register.

OUTSTANDING SCIENTIFIC EXHIBITS

Realizing that exhibits form an important part of postgraduate medical education, the Council on Scientific Work has arranged, for the One Hundred First Anniversary Meeting, September 14, 15 and 16, the largest scientific exhibit section ever to be presented before your Society.

The exhibit prepared by Dr. Eben J. Carey, dean of the Marquette University School of Medicine and awarded the Gold Medal at the American Medical Association's annual meeting will be one of the main features. Other exhibits will cover such current subjects as civilian defense, fenestration operation for the improvement in hearing in otosclerosis, bronchoscopy, applied anatomy, and plastic surgery.

Unusual Explosion Wrecks Dr. C. A. Dawson's Home

Below is pictured the wreckage which was caused by an explosion in the home of Dr. C. A. Dawson of River Falls on July 16. The accident occurred when the girl employed in the Dawson home attempted to light a water heater in the basement. A leak of bottled gas had occurred, filling the basement with fumes, and as a result when a match was lighted, a severe explosion took place. The *Hudson Star Observer* contained the following news item on the accident:

"Bernadine Cobian, 16, was injured painfully Thursday in an explosion which wrecked the home of Dr. C. A. Dawson. Dr. Dawson was state commander of the American Legion in 1931–1932.

"The blast occurred when the girl attempted to light a water heater in the basement. The first floor of the house bulged upward almost two feet, furniture was hurled about, plaster was ripped from the walls and windows were shattered.

"Miss Cobian was alone in the house. Mrs. Dawson was in the yard and her infant granddaughter was asleep on the front porch."

Dodge County Medical Society Presents Health Exhibit at County Fair

Under the supervision of Dr. E. C. Hoyer of Beaver Dam, the Dodge County Medical Society displayed the health exhibit, prepared by the Committee on Health and Public Instruction of the State Society, at the Dodge County Fair, June 30 through July 5. The exhibit was enthusiastically received by the county medical society, and hundreds of local residents welcomed the opportunity to become acquainted with the operations of the fluoroscope.

Through the courtesy of the General Electric X-Ray Corporation a portable x-ray unit was installed in the county fair exhibit, and visitors to the booth were given an opportunity to inspect their hands, wrists and elbows by mean of the fluoroscopic unit.

The background of the exhibit is comprised of six brightly colored nursery rhyme characters. Below each of these characters appears a nursery rhyme paraphrased to convey health information.

The Dodge County Society was supplied with sample literature, emphasis being given to both the pamphlets on "Mother Goose Rhymes" which are available through the Committee on Health and Public Instruction, and the supplement of *The Wisconsin Medical Journal* entitled "Health and Food." Other pamphlets were made available through the State Board of Health.

The exhibit will be shown at the state fair and at several county fairs during the current season.

The exhibit prepared by the Committee on Health and Public Instruction which was used by the Dodge County Medical Society at the county fair, June 30 through July 5.

In the above picture, Dr. Xavier Corso, Beaver Dam, is demonstrating the fluoroscopic unit. From left to right, Mr. Carl Schuster, Mrs. James Malone, wife of the secretary of the Dodge County Fair Association, Mrs. Carl Schuster and Dr. Corso.

Society Proceedings

Clark

All the present officers of the Clark County Medical Society were re-elected at the monthly meeting held on July 14 at Greenwood.

Douglas

When Dr. Fred G. Johnson, secretary of the Douglas County Medical Society, sent out notices for the June meeting at Indianhead Lodge, near Iron River, he announced that the members would be dinner guests of the county society officers. Twenty-three members and guests were present at the meeting, which marked the close of the year's activities.

Dr. James W. McGill read a paper on "The Treatment of Wounds Which Might be Incurred during Wartime."

Fond du Lac

The final meeting of the season of the Fond du Lac County Medical Society was held on June 25 at St. Agnes Hospital, Fond du Lac. This was a business meeting and was held in conjunction with a staff meeting of the hospital.

Polk

Members of the Polk County Medical Society were dinner guests of Dr. Valentine C. Kremser of Amery at Hickory Point Resort, Amery, on July 16.

Following the 7:00 dinner, Dr. Ernest M. Hammes, professor of nervous and mental diseases at the University of Minnesota Medical School, Minneapolis, gave a paper on "Spinal Anesthesia; With a Discussion of the Neurologic and Organic Sequelae."

Rock

Golf was enjoyed by members of the Rock County Medical Society when they met at the Beloit Country Club on the afternoon of June 24. Following a 6:30 dinner the program chairmen, Drs. Frank E. Brinckerhoff and Thomas H. Flarity of Beloit, presented Dr. Lindon Seed, associate professor of surgery of the University of Illinois College of Medicine. He spoke on "Tumors and Cysts of the Neck."

Sheboygan

Thirty-five members of the Sheboygan County Medical Society met at Dr. Arthur J. Knauf's cottage at Crystal Lake on July 14, where they enjoyed a bratwurst roast. After the meal a general discussion on fee schedule revisions was held, following which a social evening was spent by the physicians.

Trempealeau—Jackson—Buffalo

When the Trempealeau–Jackson–Buffalo County Medical Society held its monthly meeting on July 16 it was the first time that the group had met in Mondovi. The meeting was held at the Mondovi Clinic following a 6:30 dinner. Dr. F. E. Butler of Menomonie, president-elect of the State Medical Society, spoke on "The Life and Function of our State Medical Society."

Waukesha

The annual picnic of the Waukesha County Medical Society and the Woman's Auxiliary was held at the Merrill Hills Country Club, Waukesha, on July 8. A dinner and social evening followed a golf tournament, in which Dr. Frederick J. Woodhead, Waukesha, and Dr. J. Francis Wilkinson, Oconomowoc, were winners.

Winnebago

The annual social meeting of the Winnebago County Medical Society was held on Saturday, July 25, at the Ridgeway Golf Club, Neenah. Entertainment included golf, softball, and horseshoe pitching, and a chicken dinner was served at the clubhouse. Dr. Gerhard R. Anderson and Dr. Raymond H. Quade, both of Neenah, were in charge of arrangements.

Milwaukee Society of Clinical Surgery

At an executive committee meeting of the Milwaukee Society of Clinical Surgery held in Milwaukee on June 11, it was unanimously voted to change the name of the society to the Wisconsin Academy of Surgery. It was hoped that in this way the organization in the future would be more representative of the general surgeons of the state. The executive committee has also announced that future membership in the Wisconsin Academy of Surgery will be limited to Fellows of the American College of Surgeons and Diplomates of the American Board of Surgery.

News Items and Personals

Lieutenant Colonel Amory A. Miller, executive officer of the Wisconsin military headquarters in the Federal Building, Milwaukee, has announced that First Lieutenant Paul Binder of the Army Medical Corps has been stationed there to assist in the recruiting of physicians and surgeons under 35 for the Army Air Force medical staff.

Lieutenant Binder, whose home is in Chicago, came to Milwaukee from Scott Field, Illinois. A physician, he will answer queries of young physicians and surgeons interested in training at the School of Aviation Medicine at Randolph Field, Texas, for commissions as flight surgeons or regular Army doctors. About 20 per cent of all physicians taken into the Army are needed in Air Force medical work, according to Lieutenant Binder. His office is in room 559 at the Federal Building.

Dr. Arnold S. Jackson, Madison, presented a paper on "The Use of the Sulfonamide Drugs in Surgery" at the International College of Surgeons in Denver on July 15.

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Members of the Rotary Club of Janesville heard *Dr. Thomas J. Snodgrass* of that city discuss "Emergency Medical Work" at a luncheon meeting held in the Monterey Hotel on July 13.

On July 20 *Dr. Margaret E. Hatfield*, director of the Rock County sanitary unit, spoke to the same group on the work of county nurses in guarding the health of Rock County rural children.

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Dr. John K. Shumate, superintendent and medical director of the Pureair Sanatorium, Bayfield, for the last eleven years, will soon take up his duties as superintendent and medical director of Lake View Sanatorium, Madison.

The appointment of *Dr. Mead Burke* as acting assistant superintendent of the Wisconsin General Hospital, Madison, was announced on July 13 by *Dr. Harold M. Coon*, superintendent.

Dr. Burke, who has been associated with the hospital since 1935, is also chief resident physician and chief admitting officer.

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Dr. John D. Steele, Milwaukee, was recently appointed to the Tuberculosis Sanatorium Consultation Committee of the State Board of Health by *Dr. C. A. Harper*, secretary of the Board. He will fill the vacancy created by the induction of *Dr. Joseph W. Gale*, Madison, into the United States Army. *Dr. Harold M. Coon*, Madison, and *Dr. Calvin M. Yoran*, Plymouth, will continue as the other members of this committee.

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Two United States Army surgeons, one of them *Lieutenant Mark M. Temkin*, of Beaver Dam, have been credited with a delicate brain operation performed "somewhere in Australia" which saved the life of an American soldier.

Working in a field hospital, the doctors removed the nose cap of a shell fired by a Japanese zero fighter and also took out a piece of bone which was pressing on the brain center. The patient was tail gunner of a bomber which was involved in Allied raids in New Guinea.

Dr. Temkin was born in Russia. His family came to Beaver Dam in 1917. He attended the University of Wisconsin Medical School and upon graduation joined the medical reserve corps. Following his internship at Milwaukee County Hospital, *Dr. Temkin* returned to Beaver Dam to practice medicine. He entered the Army in August, 1941, and was stationed at Camp Forrest, Tennessee. In February, 1942, he was transferred to Australia.

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Dr. Frederick G. Jensen, Menasha, was elected president of the Theda Clark Hospital staff at a meeting on July 3 in Neenah. He succeeds the late *Dr. Ronald B. Rogers*, Neenah. Other officers named were *Dr. Matthias N. Pitz*, Neenah, vice-president, and *Dr. John P. Canavan*, Neenah, secretary–treasurer.

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Dr. Fred B. Welch, city health officer at Janesville, addressed the Red Cross nurses' aide candidates on "The Control of Communicable Diseases in the Community" on June 22.

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Dr. Walter J. Urben, senior physician at the Mendota State Hospital, Mendota, has been appointed director of the Division of Mental Hygiene, according to a recent announcement by the State Department of Public Welfare. He will fill the vacancy caused by the death of *Dr. Gilbert E. Seaman*, Madison, on May 24, 1941.

The new director was born at Monticello and was graduated from the University of Wisconsin Medical School in 1930. He is a member of the Dane County Medical Society, the State Medical Society, the American Medical Association, and the American Psychiatric Association.

Before coming to the Mendota institution, Dr. Urben acted as assistant superintendent of the Massilon State Hospital in Ohio; senior physician at the Southern Wisconsin Colony and Training School, Union Grove; and staff physician at the Milwaukee County Hospital for Mental Diseases. He will take up his new duties immediately.

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When the Minnesota State Medical Association held its annual meeting in Duluth on June 29, 30, and July 1, several Wisconsin physicians were guest speakers. *Dr. Armand J. Quick*, editor of *The Journal's* page entitled "Comments on Treatment" and associate professor of pharmacology at Marquette University School of Medicine, gave a paper on "The Present Status of the Hemorrhagic Diseases." He also gave a radio talk over station WEBC on "Recent Advances in Preventing Blood Clots after Operation."

Dr. William C. Keettel, consultant for the State Board of Health, Madison, gave obstetric demonstrations on June 29 and 30. He also participated in a symposium.

Dr. Ferdinand H. Haessler, a staff member of Columbia and Milwaukee Children's Hospitals, spoke on "Ocular Tuberculosis" on July 1 at the Duluth meeting and also took part in a symposium on eye, ear, nose and throat.

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All first-aid classes in the vicinity of Argyle will be under the supervision of *Dr. Walter B. Williams*, who was recently appointed official instructor by the Lafayette County Chapter of the Red Cross.

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Dr. Herbert F. Sydow, Waukesha, has been chosen physician for the Waukesha County Asylum and Home, it was announced June 19. He will succeed *Dr. Richard E. Davies*, who had served in that position since 1914 and resigned, as he said, "to give someone else a chance."

BIRTHS

A daughter, Ida, to Dr. and Mrs. Carl Milchen, Blair, on May 24.

A son to Dr. and Mrs. Sverre Quisling, Madison, on July 6.

A son, David Michael, to Dr. and Mrs. Jacob B. Ozonoff, Milwaukee, on July 7.

MARRIAGES

Dr. Joseph W. Rastetter and Miss Gertrude Neville, both of Milwaukee, on May 9, at Milwaukee.

Dr. Herbert B. Christianson, Superior, and Miss Alice Keller, Savannah, Georgia, on April 1 at Fort Devens, Massachusetts.

DEATHS

Dr. Thomas W. Tormey, Sr., prominent Madison physician and surgeon, died on July 8 at a Madison hospital following a brief illness. He had entered the hospital June 24 for treatment and failed to rally after two operations. A physician and surgeon in Madison for the last thirty-eight years, Dr. Tormey was widely known for his skill in surgery and was sometimes referred to as "the dean of the medical profession in Dane County."

He was a fellow in the American College of Surgeons, and a member of the American Medical Association, the State Medical Society of Wisconsin, the Dane County Medical Society, and the American Railway Surgeons. He was a staff member of St. Mary's and Madison General Hospitals and was formerly chief of staff of the latter.

Born in 1878, Dr. Tormey was the son of Mr. and Mrs. Thomas Tormey, pioneer residents of Madison. He was educated in Madison public schools and did his premedical work at the University of Wisconsin. He received his degree of doctor of medicine from Rush Medical College, Chicago, in 1902. His internship was served at St. Luke's Hospital in Chicago.

When he was licensed to practice in 1904, Dr. Tormey opened offices in Madison. Later he was joined in practice by his brother, Dr. Albert R. Tormey. In recent years the Tormey Clinic had been expanded to include Dr. Thomas Tormey's two sons, Dr. Thomas W. Tormey, Jr., and Dr. Weston C. Tormey.

An ardent circus fan, Dr. Tormey was for many years a national director of the Circus Fans of America Association. Each summer for the past twenty years he had traveled hundreds of miles to see performances of circuses, large and small. Early this year he went to New York especially to see the 1942 opening of the Ringling Brothers and Barnum & Bailey Circus. He was known also for his keen interest in civic affairs.

Survivors include his widow; two sons, Dr. Thomas W. Tormey, Jr., Nakoma, and Dr. Weston C. Tormey, Maple Bluff; two daughters, Mrs. Rolf Darbo, Madison, and Mrs. Joseph Werner, Washington, D. C.; one brother, Dr. Albert Tormey of Madison; six sisters, Mrs. George Benisch of Milwaukee, Mrs. James O'Hora and Mrs. Ella Doherty of Detroit, and the Misses Marion, Julia and Frances Tormey, all of Madison.

Dr. Ernest L. Schroeder, 56, former president of the Shawano County Medical Society and ex-mayor of the city of Shawano, died at his home there on July 7 following an illness of several months.

A civic leader in his community since 1915, Dr. Schroeder was a member of the Shawano County Medical Society, the State Medical Society of Wisconsin, the American Medical Association, and the American College of Surgeons. He was also a member of the American Legion and the Municipal Hospital staff. He served as visiting physician at the Shawano County Home for seventeen years and for ten years was a member of the University of Wisconsin Board of Regents. His illness forced him to resign as mayor of Shawano and as chairman of the Shawano County Council of Defense.

Dr. Schroeder, a native of Wisconsin, was graduated from the Oshkosh Normal School in 1908 and taught for a brief period in the Shawano high school. Later he studied at the University of Wisconsin and was graduated from Northwestern University Medical School in 1914. The following year he returned to Shawano to practice medicine. In 1915, Dr. Schroeder enlisted in the Army and served as a major overseas in the first World War. Upon his return to Shawano he resumed his practice.

He is survived by his widow and two children, Betty Rae and Robert.

Dr. Melvin L. Young died at his home in Ashland on June 27 at the age of 83.

He was born in the province of New Brunswick, Canada, and taught school there for several years. During that time he studied medicine under a local physician. Later he attended the University of the City of New York and was graduated in medicine in 1885. For thirty years he practiced in Maine and New Brunswick and served, during most of that time, as medical inspector in the United States Marine Hospital Service. Twenty-six years ago Dr. Young began his practice in Ashland.

Dr. Young was a former member of the Ashland–Bayfield–Iron County Medical Society, the State Medical Society of Wisconsin, and of the American Medical Association.

He is survived by his widow.

Dr. William S. Darling, 65, died at his home in Milwaukee on June 16. He had been in ill health for several years.

A member of St. Joseph's Hospital staff, Dr. Darling had been practicing in Milwaukee since 1903. He was born in Shirland, Illinois, attended the University of Wisconsin, and was graduated from Marquette University School of Medicine. He entered general practice immediately after his graduation. In 1917 and 1918, he served with the United States Army as captain of a medical corps at Camp Upton, Long Island, New York.

Dr. Darling was affiliated with the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

In addition to his widow he is survived by a daughter, Mrs. Dorothy Kintzele; his mother, Mrs. Ella Darling, and two brothers, Drs. Frank and Earl Darling.

Dr. Walter T. McNaughton, medical director of the Old Line Life Insurance Company and active in private practice in Milwaukee for many years, died of a heart attack in his office on July 6. He was 62 years of age.

Dr. McNaughton had practiced medicine in Milwaukee since his graduation from the former Wisconsin College of Physicians and Surgeons, now

Marquette University School of Medicine, in 1904. He lived in Milwaukee all his life. Besides caring for an extensive private practice, he was medical director of the Old Line Life Insurance Company.

Dr. McNaughton was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. He was also affiliated with the Milwaukee Academy of Medicine, the Medical Directors' Association and the American Heart Association.

He is survived by his widow; a brother, Charles, and a sister, Alberta.

Dr. Albert A. Maurer, 83, a former La Crosse physician, died at a hospital near Patterson, New Jersey, on June 29. Although he had moved to New York City upon his retirement in 1926, he was widely known throughout the southwestern part of the state.

He obtained his medical training at Rush Medical College in Chicago, from which he was graduated in 1882. Four years later Dr. Maurer came to La Crosse where he practiced for forty years, with the exception of two years spent as a captain in the Army Medical Corps during World War I.

Dr. Maurer was a prominent physician and surgeon and was instrumental in the founding and establishment of the La Crosse Hospital in 1900. He gave up his practice in 1926 and moved to New York, where he was associated with the Marinello Company.

He was an honorary member of the State Medical Society of Wisconsin, a member of the La Crosse County Medical Society, and of the American Medical Association.

Surviving him are his widow; two sons, Albert of Milwaukee and Claude, Madison, and a brother, Edward Maurer, dean emeritus of the School of Engineering at the University of Wisconsin.

Dr. George G. Wallschlaeger, 50, died on July 13 at his home in Milwaukee, where he had lived and practiced medicine for twenty-three years.

Born in Milwaukee, Dr. Wallschlaeger received his medical degree from the Chicago College of Medicine and Surgery in 1917. He served in France during the last war as a lieutenant in the Medical Corps. After he was licensed in 1919, he established a practice in Milwaukee. Two years later he became affiliated with the medical staff of the Milwaukee Electric Company, which association continued up to the time of his death. He was also on the staffs of St. Mary's and St. Luke's Hospitals.

Dr. Wallschlaeger was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are two aunts, Mrs. Clara Peschman of Chicago and Mrs. Michael Baumgartner of Milwaukee, and a brother, Gustav Prasser of Milwaukee.

Dr. William P. Jobse, 81, died at his home in Milwaukee on July 20. He had practiced medicine for more than 40 years before his retirement in 1941.

A native of Milwaukee, Dr. Jobse was graduated from the Chicago Medical College, now the Northwestern University Medical School, in 1884. He continued his studies in Milwaukee and was licensed to practice in 1899.

Dr. Jobse was a member of the Medical Society of Milwaukee County, and served as president of that organization in 1906. He was also a member of the State Medical Society of Wisconsin and the American Medical Association, and in 1937 was elected to life membership in the former. During the last war Dr. Jobse served as a medical examiner in Milwaukee.

Surviving are three daughters, Mrs. Amy Hahn, Milwaukee; Mrs. Myrtle Scott, Niagara Falls, New York; and Mrs. Mable Sawtelle, Crestwood; and two sisters, Mrs. Lavina Tillema and Mrs. Elizabeth Post, both of Milwaukee.

Dr. Anthony H. Nainka, 79, Gleason, died on July 11 following an illness of two years.

A retired physician and surgeon, Dr. Nainka was a graduate of the University of Vienna. He came to Milwaukee in 1897 and subsequently removed to Gleason, where he practiced medicine for twenty years.

He was formerly a member of the State Medical Society of Wisconsin and the American Medical Association.

Dr. Nainka is survived by his widow, and two brothers in Austria.

SOCIETY RECORDS

New Members

John Juhl, Washburn.

C. H. Bachman, Milwaukee.

Changes in Address

Edward Palmer, Hillsboro, to Suite 804, 7 West Madison Street, Chicago, Illinois.

R. P. Wiesen, Wauwatosa, to 1409 North Twenty-seventh Street, Milwaukee.

E. X. Thompson, Milwaukee, to Drayden, St. Mary's Co., Maryland.

E. W. Miller, Milwaukee, to Route 1, Colgate.

H. F. Ringo, Montreal, to 1717 Kane Place, Milwaukee.

L. E. Gallett, Lake Mills, to Pulaski.

L. C. Davis, Richland Center, to Veteran's Administration, Waco, Texas.

G. W. Malin, Minneapolis, to 1404 Main Street, La Crosse.

C. J. Radl, Philadelphia, to Episcopal Eye, Ear, Nose and Throat Hospital, Washington, D. C.

T. M. Slemmons, Ancon, C. Z., to Dispensary, Pedro Miguel, Panama Canal Zone.

G. W. Marbry, Madison, to 1113 Miller Avenue, Oak Park, Illinois.

A. R. Kaufman, Mauston, to 408 Charles Avenue, New Kinsington, Pennsylvania.

O. L. Puttler, Mauston, to 5700 Broadway, Oakland, California.

Minutes of the Council; Madison, July 12, 1942

1. Call to Order

The Council convened at 9:00 a. m., Sunday, July 12, 1942, at the Madison Club, Madison.

2. Roll Call

The following were present, constituting a quorum: Councilors Gavin, Pechous, Clark, Pippin, Jegi, Krahn, Christofferson, Arveson, Gramling, Fitzgerald, Blumenthal and Lambert; President Gundersen; Past-president Sproule; President-elect Butler; Treasurer Sisk; Speaker Kurten; Secretary Crownhart; and Assistant Secretary Larson. Dr. C. A. Dawson, River Falls, chairman of the Committee on Public Policy, was a guest.

3. Approval of Minutes of January Meeting

It was moved by Fitzgerald–Jegi that the minutes of the January meeting of the Council, as published in the February issue of *The Wisconsin Medical Journal*, be approved. Motion carried.

4. Special Dues-paying Classification for Residents and Research Fellows

The Council considered the report of the Special Committee on Constitution and By-laws of the House of Delegates relating to per capita reduced dues for those licensed as physicians, not engaged in actual practice, but pursuing special work as residents or research fellows. This proposal, originating from the Dane County Medical Society in 1941, was referred to the Council for study and subsequently to the special committee for report. After consideration of the committee's report, suggesting such amendment on the basis of $2 per capita dues, with at least $1 being remitted to the State Society, and upon discussion by Councilors Pechous, Arveson, Gramling, Fitzgerald, Krahn, Lambert and Clark, and President-elect Butler, President Gundersen and Speaker Kurten, it was moved by Fitzgerald–Arveson that the matter again be referred to the committee for report to the Council at the September meeting. The motion stated that the committee should be advised that the Council was of the opinion that further emphasis should be placed on licensure as a condition to such privilege; that such privilege should not be extended beyond a three-year period, and at dues not to exceed $5, $3 of which should be remitted to the State Society. It was the expressed opinion that such dues would more nearly reimburse the Society for actual mailing costs of *The Journal*, special bulletins, and other material.

5. Membership and Delegate Representation

Because of the situation created by the fact that dues of members of the Society in military service are prorated on a monthly basis as of the time they are inducted into service and waived for the duration of such service, the secretary suggested that definite action be taken by the Council to treat the status of such members as within the term "fully paid" when used in connection with delegate representation. After discussion, it was moved by Arveson–Lambert that the following resolution be adopted:

"*Resolved*, That the term 'full-paid members' as used in Chapter III, Section 2 of the By-Laws is properly construed to include those who by reason of military service are entitled to full waiver of dues or are obligated to and have paid pro rata dues."

Motion carried unanimously.

6. Associated State Committees on Postgraduate Medical Education

Councilor Krahn presented a request for financial support from this organization, established in 1936 for the purpose of developing facilities and sources of information dealing with problems of postgraduate medical education. After discussion by Councilors Clark, Gramling, Blumenthal, Fitzgerald and Pechous, President-elect Butler and Speaker Kurten and after noting the support given the organization by the Michigan State Medical Society, it was moved by Clark–Gramling that the requested amount of $50 be contributed with the understanding that the Society was not otherwise committing itself. Motion carried.

7. Committee on War Participation

Chairman Gavin called upon Councilor Fitzgerald, as chairman of the present Committee on Medical Defense (formerly the M–Day Committee), to explain and outline generally the activities of this committee and the Society in connection with the war effort, with special reference to the Procurement and Assignment Service. Dr. Fitzgerald outlined to the Council and guests the procedures followed under his direction as state chairman of Procurement and Assignment. He discussed the reasons therefor, the results obtained and expected to be obtained in the future in securing adequate medical personnel for the armed services of the country, and the problem of properly distributing medical service in those communities found wanting after a required large number of physicians were inducted into service. Discussion followed in which all present participated, after which Chairman Gavin called upon Secretary Crownhart to outline the activities and results accomplished from the standpoint of the executive office of the Society. After further discussion, the committee suggested that the name of the present Council Committee on Medical Defense (formerly the M–Day Committee) be changed to the Council Committee on War Participation, more properly to denote its present efforts, and that under this committee there be appointed three subcommittees, namely: (1) Subcommittee on Procurement and Assignment Service; (2) Subcommittee on Re-

placements; and (3) Subcommittee on Civilian Defense, thus correlating all activities under one general masthead.

It was moved by Krahn–Jegi that the recommendations concerning changing the name of the committee to Committee on War Participation and appointment of the three suggested subcommittees be approved in the manner set forth. Motion carried.

8. Wisconsin State Board of Medical Examiners

Councilors Arveson and Christofferson discussed the recent meeting of the Wisconsin State Board of Medical Examiners and problems and matters before that body at that time. No specific action by the Council was indicated.

9. Farm Security Administration

The report of the Committee on Voluntary Sickness Insurance with reference to pending proposals of the Farm Security Administration was discussed at length. It was moved by Pippin–Christofferson that the trial plan presented by the committee be referred to the Farm Security Administration as the Society's final thought at this time. Motion carried.

10. Counsel for the Society

After general discussion, it was moved by Arveson–Pechous that Mr. Robert B. Murphy, Madison, be retained as counsel for the Society.

11. Budget Adjustments

Secretary Crownhart discussed the increased burdens and added costs in the executive office caused by the country's participation in the war and pointed out that certain budget adjustments were necessitated at the present time. After general discussion, Jegi–Krahn moved that the following adjustments in the 1942 fiscal budget be made:

Increase the appropriation for Item I–7 of the budget,—secretary travel	$ 275	(new total, $1,275; 1941 total, $1,000)
Increase tbe appropriation for II–9, assistant secretary travel	175	(new total, $475; 1941 total, $300)
Increase the appropriation for III–17B, telephone and telegrapb	700	(new total, $1,400; 1941 expenditures were $850)
Total	$1,150	

These increases are to be provided from the following budget sources, and without increasing the 1942 budget in any respect as a whole:

Item IV–(A)–19 Special bulletins to members, approximately	$ 200
Item VI–(A)–1941 panel appropriation, panel preparation, balance being about	550
Item VI–(B)–1941 physical examination in industry unused appropriation, about	400
Total	$1,150

Motion carried.

12. Industrial Health Postgraduate Clinics

Chairman Gavin called upon Dr. R. M. Kurten, as a member of the Committee on Industrial Health, to discuss the recommendation of his committee and the Council on Scientific Work that an industrial health postgraduate clinic be held before the end of 1942. The importance of industrial medicine in the war effort was stressed by Dr. Kurten; and Dr. G. W. Krahn, representing the Council on Scientific Work, amplified the subject. After discussion by Councilors Gavin, Blumenthal, Krahn and Pechous, and Speaker Kurten, it was moved by Fitzgerald–Christofferson that such a postgraduate industrial clinic be authorized and that the Society should underwrite a possible loss to the extent of $450, if necessary, this amount being an unexpended balance after the 1942 spring clinics.

13. Recognition of Rights of Physicians in the Armed Services

Secretary Crownhart presented to the Council a placard used by a county bar association in Wisconsin, the subject of which is the protection of professional practice of those members in the armed forces. It was suggested that a similar device might be used for the medical profession. After discussion, it was moved by Past-president Sproule, variously seconded, that such a device be adopted by the State Medical Society of Wisconsin for distribution to physicians and hospitals and that the mechanics of the project be left to the discretion of the secretary's office. Carried unanimously.

14. The Society and the War Effort

Late in the morning session, Lieutenant Colonel Amory A. Miller and Captain Norman L. Sheehe of the Medical Officer Recruiting Board, Milwaukee, arrived as invited guests of the meeting. Chairman Gavin called upon Colonel Miller, who presented problems encountered in securing sufficient medical officers to serve the armed forces. Captain Sheehe amplified the remarks, after which Chairman Gavin thanked the officers.

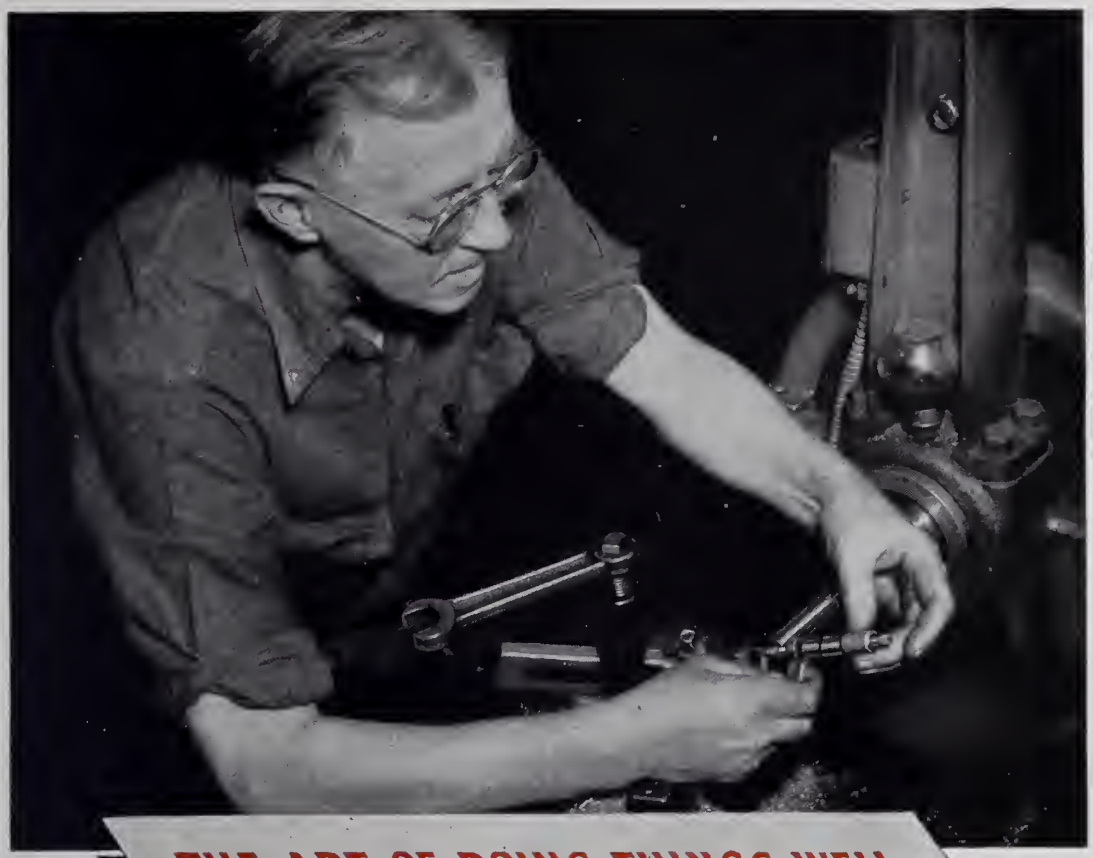
The meeting recessed for dinner at 12:30, resuming at 2:00 p. m., with Dr. Amy Louise Hunter, chief of the Bureau of Maternal and Child Health of the Wisconsin State Board of Health, and Dr. William C. Keettel, obstetrical consultant for the same Board, as guests.

15. Dr. F. G. Johnson

After unanimous official note of the fact that Dr. F. G. Johnson of Iron River, councilor from the Eleventh District, has been ill and was unable to attend this meeting, the secretary was instructed to transmit a telegram of good wishes to Dr. Johnson, on behalf of the Council and officers of the Society.

16. Obstetric and Pediatric Care for Wives of Soldiers and Sailors

Chairman Gavin called upon Dr. Hunter to explain the federal proposal, as submitted to her bureau, for subsidization of costs of obstetric and pediatric care for wives of soldiers and sailors when payment cannot be made in the customary manner. The technical problems involved were discussed by Dr. Hunter and amplified by Dr. Keettel. Discussion by the councilors and officers followed. It was moved



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by Krahn–Jegi that this matter be re-referred to the Committee on Maternal and Child Welfare of the Society for further study and recommendation, in view of the changing circumstances and to ascertain what has been done by our neighboring states. The motion further recommended that the committee express an opinion to the State Board of Health that the avenue should be left open to obtain the federal appropriation for Wisconsin along such lines as later might be indicated without commitment as to what the definite plan might be. Motion carried.

17. Procedural Problem Relating to Scientific Sections of the Society

Secretary Crownhart presented the question of whether scientific sections of the Society should vote upon applications to membership in the various sections, stating that the matter had been presented to the secretary's office by one of the sections of the Society. After discussion, it was moved by Councilor Blumenthal, variously seconded, that no provisions should be incorporated into the constitution and by-laws of any scientific section of the Society providing for vote on membership in such section. Motion carried.

18. Report of the Committee on Life Membership

Assistant Secretary Larson explained the tentative proposal of the Committee on Life Membership. After general discussion, it was moved by Krahn–Jegi that the committee be consulted as to the advisability of further clarification with the suggestion that the name of the procedure for the temporary remission of dues be changed to one more appropriate to the purposes intended.

19. Council Award

The Executive Committee of the Council reported that it had no nominations for the 1942 Council Award and recommended that suggestions be sent to the secretary's office.

20. Minnesota State Medical Association Meeting

Chairman Gavin discussed his attendance at the annual meeting of the Minnesota State Medical Association and some of the pertinent points concerning the meeting with regard to procedures, and so forth.

21. State Society Thanked by Dr. Harper

Dr. C. A. Harper, state health officer, and secretary of the Wisconsin State Board of Health, attended a part of the meeting and was welcomed by the officers, councilors and guests. He addressed the meeting, thanking the State Society for its efforts and cooperation with his Board.

22. Adjournment

The meeting adjourned at 3:10 p. m.

C. H. Crownhart
Secretary

Approved:
S. E. Gavin
Chairman of the Council

Prompt Reports by Physicians Necessary in Workmen's Compensation Cases

By HARRY A. NELSON
Director, Workmen's Compensation, Industrial Commission of Wisconsin
Madison

AT THIS time, injury cases under the workmen's compensation act are being reported to the Industrial Commission at the rate of approximately 30,000 per year. These are cases in which disability of more than three days has resulted. A large additional number of cases are not reported to the Commission because of lesser disability.

In practically all cases, the injured employe is treated by a physician. The questions of whether or when he will receive compensation depend almost invariably upon examination and report by a physician. Failure or delay on the part of the physician in reporting to the employer or insurance carrier as to the nature and extent of disability may mean suffering and hardship to the employe because of delay in payment of compensation. Some employes may actually be denied the necessities of life, at least temporarily, because of failure on the part of the doctor promptly to make the report upon which payment of compensation depends.

Because of these and other factors, insurance carriers, in collaboration with the State Medical Society, have evolved a panel plan under which those physicians who are members of the Society may treat injured employes. When the provision was adopted, it was expressly agreed that certain obligations were to be undertaken by the physicians. Among these obligations were those

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of making prompt and necessary reports to the employer and insurance carrier and replying promptly to correspondence and requests for information as to disability of an employe. Every physician who has requested the posting of his name on the panel has agreed to undertake the obligations which have been imposed.

On the whole, the plan has operated admirably with a few exceptions which have arisen because of failure on the part of a small number of physicians to comply. It is hoped that all physicians will appreciate the importance of complying with the obligations undertaken. The Industrial Commission believes that the duty imposed upon it demands action on its part to insure that names of physicians who repeatedly fail to make prompt reports without proper explanation for their failure are removed from future panels.

We all know that present times are arduous and even harassing ones for physicians. However, the Commission fully recognizes its obligation under the law and asks that special effort be exerted on the part of physicians to maintain the high standards which have been created by the Commission, the insurance companies and employers, and the vast majority of physicians who have treated injured employes heretofore.

The Commission and insurance carriers have adopted detailed report forms for the use of physicians in making reports. These forms have been studied carefully from time to time in order to keep requested items down to a minimum. While to some physicians they may seem longer than necessary, the information which is requested is necessary in order properly to evaluate disability and to make payment of medical bills and compensation benefits.

At times, physicians have informed the Commission that their failure to report is because there is nothing to report. It is obvious that the fact that no information is obtainable is of just as great importance in the determination of a case as is definite information which may lead to an award. Both physicians and the Industrial Commission, as well as the office of the State Medical Society, will be saved much time and expense if requests made to physicians as to status of cases are answered immediately, giving such information as is obtainable, or stating that no information can be given, if that is the fact.

The old saying that "justice delayed is justice denied" truly was never more applicable than in compensation cases, where speed in payment of benefits is the very essence of the remedy. The keystone to success of the entire compensation structure is often the attending physician, and it is his prompt and assiduous attention to a case, not only in the way of treatment, but in the making of prompt reports, which insures the carrying out of beneficent social intent inherent in the remedy provided by the compensation act. To the many physicians without whose cooperation this objective could not have been realized, the Commission expresses its thankful gratitude.

The Part of the Medical Man in Traffic Accident Prevention

By MORRIS W. SHERWOOD, M. D.*
Milwaukee

IN a year when the need of human energy and natural resources proved more desperately urgent than ever before, the American people with heedless abandon proceeded to kill and cripple more of their number and to demolish more of the nation's mechanical facilities than in any year in American history.

During 1941, in motor vehicle accidents, 40,000 Americans were killed; almost 1,500,000 were injured; and more than 1,000,000 automobiles were damaged. That's

* Chairman, Committee on Safety on Public Highways, State Medical Society of Wisconsin.

the record of 1941—a record that rips to shreds all previous yearly totals—a record that should leave every American with a sense of shame and should move every one of us to resolve that it shall never happen again.

Even now the outlook for 1942 is unfavorable. For the first quarter of the year—in spite of tire rationing, in spite of automobile rationing—motor vehicle deaths do *not* show any decrease!

The doctor has more than an academic interest in this slaughter. In 1940 and 1941 motor car fatalities exceeded the number of deaths which, had it not been for preventive medicine, would have occurred as a result of the principal diseases of childhood. And if the upward trend in the motor car massacre continues, it is conceivable that it will entirely nullify the number of lives saved in recent years from the ravages of diphtheria. There is no profit in saving children from diphtheria if they are going to be killed on the streets—or in prolonging the lives of diabetics merely to have them die horribly on the highways.

It is interesting to speculate on the genesis of traffic accident prevention work. Whatever the reason may be, traffic accident prevention work, in relation to human behavior, unwittingly proceeded under a handicap because it was not united with its logical allies, those in preventive medicine and public health education. It was therefore divorced from the discipline which those in these fields could have contributed through their experience and knowledge of how to approach problems by the use of known or indicated methods.

Understanding concerning the accident problem would be greatly clarified if we established the axiom that the function of the medical profession is to conserve life; that there is no accepted variation of this definition which places a waiver, so to speak, on any specific hazard; and therefore traffic accident prevention is fundamentally a problem of preventive medicine.

Five Causative Factors

In terms of simple analysis, it may be said that there are five factors which either singly

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or in combination cause motor accidents: road conditions, ineffectual traffic control systems, violation of law, the car, and the actions of the driver.

In the first three factors there is evidence that those responsible are at least headed in the direction of ultimate satisfactory solutions. Concerning recent automobile styling, one does not feel quite so optimistic. One can only hope that certain features are merely transitory fads. One is inclined to suggest that engineering could learn something from both medicine and psychology in connection with such matters as posture, fatigue, vision, and age-old habits which conflict with the demands made upon us by the car.

When we come to education of the man behind the wheel, Medicine can view Safety's difficulties with sympathetic understanding, because what safety education is trying to achieve is analagous to an important current phase of preventive medicine—the instruction of the individual. In preventive medicine this instruction is based on considerable knowledge of the contributory and causative factors leading to disability or death. Can the same be said of the variations of human behavior as a contributing cause in automobile accidents? Unfortunately the answer is "no," and herein lies the obstacle to progress in reducing the accident toll by present methods.

In its vigorous and sincere attempts at education, safety propaganda lays emphasis on "care" and "courtesy." The trouble with the first is that it is predicated on the untenable assumption that an appreciable number of drivers are potential homicides or suicides; or that numerous motorists are indifferent to injury to themselves or others, or damage to their or other people's property. About "courtesy"—well, what is courtesy but another name for good manners? With all due deference to that delightful American institution, the "charm school," it is questionable whether courtesy is something that can be smeared on superficially like a cosmetic. Permanent success might perhaps be achieved in teaching John Doe courtesy through the medium of print if one could give the pamphlet to John Doe's deceased grandfather. Moreover, with reference to the traffic problem, there is as yet no proof that a highly intelligent boor is any more of a danger than a sweet-mannered moron.

The fear motive illustrated by such examples as horrifying descriptions of the sufferings of accident victims, or motion pictures of hairbreadth escapes from sudden death, fails because it is psychologically unsound. What the protagonists of this method do not understand is that it appeals to a sadistic tendency which is widespread in mankind, or to the closely allied basic reasons for seeing the funny side of other people's troubles.

Safety Education Disappointing

There are noticeable today two unfortunate reactions to the disappointing results of safety education. One excuses the rising toll because of the increase in motor traffic. The other, for lack of a better term, might be called the "chiropractic school of thought" because its adherents still seek to explain all happenings in terms of a single major cause. As pleas for care and courtesy have failed, the blame is now fastened onto speed, or old cars, or intoxicated drivers. It should be pointed out that Preventive Medicine can hardly accept the first viewpoint. It is too much like justifying a higher death rate per hundred thousand from preventable disease because the population has increased. The second illustrates the lack of what Henry H. James* called "tough-mindedness" in thinking—the "tender-minded" being those in whose breasts lives the eternal hope that complex questions can be quickly and easily answered by the use of a simple formula.

Naturally, if one starts from a wrong premise, it is possible to arrive by logical steps at a false conclusion which has the appearance of being right. If one assumes that the driver who was at fault in an accident was at all times the master of his actions, one looks for reasons for the accident in terms of either carelessness, thoughtless-

* Author, trustee, and director of Rockefeller Institute for Medical Research.

ness, discourtesy, or the deliberate violation of traffic laws. Admittedly, numerous accidents are traceable to such causes, but to disregard other reasons for behavior indicates that an important body of knowledge is being ignored.

Accident Statistics

Suppose we look at some accident statistics in a tolerant and inquiring frame of mind. In 1941 in the United States, reported motor accidents caused 40,000 deaths and 1,500,000 nonfatal injuries. In 26 per cent the drivers at fault did not have the right of way. In 4 per cent of the fatal cases people drove off the roadway, and in 18 per cent they were driving on the wrong side. In view of this, the question arises as to what etiologic factor can be ascribed to any one of these classifications? It is inconceivable that the reasons for the driver's peculiar actions were the same in each and every case in any one group.

Judging by Preventive Medicine's standards, present statistical information on accidents is inadequate. If the data are to have true scientific value, they must be supplemented by a clinical picture of the individual's mental and physical make-up. We know that dangerous driving practices can be traced to defects of vision, hearing and intelligence. We have every reason to suspect that other causal components include psychophysical factors affecting reaction time and judgment of space relationship, as well as the more common forms of the neuroses and psychopathic states; and physical impairments involving limitation of movement or other abnormal conditions. At present we do not know the prevalence of these conditions in relation to accidents. Not until we have established their extent and relative importance can we lay the foundation of an epidemiology worthy of the name.

Accident Prevention

Therefore, the initial approach to the problem of accident prevention should be the proper collection of statistics; one of the

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means to this end should be the use of known or indicated methods along clinical lines. Only through an appraisal of this nature can we really define the size of the problem of human behavior in relation to accidents. Obviously, if there are drivers who are a menace because of handicap of impairment, the condition could not be disclosed through the ordinary procedure of the traffic court; nor could their rehabilitation be brought about through the type of safety education at present in common use.

If the sciences which have to do with the preserving and restoring of human efficiency are to assume their rightful share of the burden of accident prevention, and contribute leadership in those things concerning which they alone have the right to speak with authority, it is well to face two practical issues. What have we to say to the public, and to what extent are we prepared to suggest a tentative technic?

First, it is suggested that the public be inoculated tactfully and gradually with the idea that Safety is remiss if it does not take advantage of the experiences, advice, and skills of the professional groups which have a record of actual achievement in the prevention of premature fatality and unnecessary suffering. Second, the situation calls for reaffirmation of certain postulates sometimes lost sight of and the presentation of an analogy applicable to our present subject. Preventive Medicine seeks knowledge of contributing and causative factors. On this, it bases its work of correcting conditions at the source, as well as teaching prevention, *but* it does not make exaggerated claims.

If after accumulating sufficient data, we disclosed an indication of cause-and-effect relationship between unsafe driving and certain physical characteristics, mental attributes, or unwise habits, we would have statistics from which, with all due caution, inferences could be drawn. We would know what lines of investigation to follow when seeking to establish the cause of some particular accident. Eventually we could look forward to the development of a satisfactory type of cautionary educational material, particularly with a view to developing a greater sense of responsibility on the part of persons who knew, or suspected, that they suffered from conditions that might militate against safe driving.

In casting about for methods of filling in the existing gaps in our knowledge, it is well to consider the limitations imposed if we examine only those who might come under examination simply because they had been involved in a mishap. A selection of this nature would color the epidemiologic picture. Furthermore, inaccuracies would creep in because of the understandable defensive attitude of those under examination. As a means toward counteracting this, there is another scientific approach that could profitably be used—the experimental method. It is not necessary to wait until accidents happen before measuring objectively some of the basic skills that compose driving ability. Many high schools now include in their curriculums a course of instruction in driving. Considering the community of interests shared by Health and Education, could not some of these groups be studied while they are learning? In some schools a study is being made of the prevalence of left-handedness and its correlation with left eye dominance. There is a possibility that this matter may have a bearing on certain driving habits which at present puzzle us. A number of equally interesting questions await investigations in a scientific spirit. To note only one, the whole question of vision has received too little attention. At present we can only guess at the probable connection between red or green blindness and inability to judge space and size relationship. A certain number of these problem cases would be disclosed by clinical examination following an accident, but the whole picture would be much more valuable if the accident data were supplemented in the manner suggested. Nor should we neglect the opportunity of corrective and preventive work in connection with such defects as might be disclosed by a study of young persons about to enter on their career as drivers.

Preventive Medicine in the Safety Movement

Preventive Medicine has no reason to feel diffident about asking for a seat at the council tables of the safety movement. Unsafe driving is as much the concern of the medical profession as unsafe milk or an unsafe water supply. There is no logic in a situation in which one group saves persons from death from disease and another group strives to prevent the same individuals from being killed on the highway, with no pooling of knowledge for the common purpose of conserving life. It is in the public interest that there should be an alliance between those who sincerely desire to protect our citizens against one specific hazard, and those who have already achieved success in many and varied battles with death and suffering.

Many accidents are caused by carelessness, discourtesy, and violation of laws, but in addition there are numerous motorists who are a menace because of impairment or disability. Such sufferers are not subjects for police action, nor can they be transformed into safe drivers unless their condition is recognized and treatment prescribed by experts. Until the extent of the problem is determined, we cannot scientifically project preventive work.

An epidemiology of accidents must include knowledge of intrinsic factors involving human deficiencies, or defects, or maladjustments, both mental and physical.

The collection of this knowledge calls for the use of the resources of Preventive Medicine. Sometimes we are apt to forget that the original meaning of the term "doctor" was "teacher." Direct participation by the medical profession in traffic safety provides an opportunity for a well rounded program. Working together with public safety authorities, yet each in spheres best suited to his training and opportunities, the corporate membership of the medical profession wields a power which, if used, can make a tremendous contribution to the prevention of death and suffering from external causes.

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FOX RIVER VALLEY PHYSICIAN NEEDS TRANSPORTATION FOR EXHIBIT

One of the exhibitors in the hobby exhibit section will appreciate some help in transporting his exhibit to the Milwaukee Auditorium. Any physician residing in the Fox River Valley who has either a station wagon or a trailer which he will make available to another physician in that area for the duration of the meeting will materially assist the hobby show exhibit if he will make his facilities known to the State Medical Society office.

State and National Positions Open; Applications Now Being Filed

State Civil Service

THE State Bureau of Personnel, Madison, announces two positions are open in the State Board of Health for qualified physicians. The beginning salary for each will be $333 a month and traveling expenses. Applications are now being received and will be considered until the needs of the service are filled. Persons accepted and certified will be rated on the basis of their training and experience and no written examination will be given.

Prerequisites of both positions are citizenship of the United States, graduation from a medical school of recognized standing, one year of general interneship in an accredited hospital, and possession of or eligibility for a license to practice medicine in Wisconsin. Both positions entail consultation service to physicians on request, conferences with institution officials and staff physicians on special problems, the preparation of summaries on advances in special fields of medicine either for publication or lecture purposes, and other duties. The positions are:

Medical Specialist in Public Health (Pediatrics). The person appointed will give consultant and advisory service to physicians, institutions and organizations throughout the state on problems arising in pediatrics and will develop the pediatric aspects of a correlated program of health education for the general public. He must have had three years' successful experience as a pediatrician and one year of specialized training in pediatrics. The beginning salary will be $333 per month and traveling expenses.

Medical Specialist in Public Health (School Health Physician). The accepted candidate will cooperate with state educational administrators in developing a program for the promotion of health education in Wisconsin public schools; he will act in an advisory capacity on student health problems and will assist in the preparation of educational pamphlets and other teaching aids for courses in health. He must have had one year of public school teaching experience or possess a teacher's certificate. He must have a degree in public health or at least one year's public health experience, and either two years' successful experience in the practice of medicine or one year of special training in pediatrics. The Bureau of Personnel, State Capitol, Madison, has a standard application form which must be filed for each examination. In requesting a blank from the Bureau, a large-sized stamped self-addressed envelope should be included.

Federal Civil Service

Applications for positions as Junior Medical Officers in Washington are now being received by the United States Civil Service Commission.

The positions are for rotating interneship and for psychiatric residencies in St. Elizabeths Hospital, a federal institution for the treatment of mental disorders in Washington, D. C. The salary is $2,000 a year.

The rotating interneship consists of one year of rotating service including medicine, surgery, psychiatry, laboratory, pediatrics (affiliation), and obstetrics (affiliation). Appointments are made on July 1 and January 1 of each year. Applicants must be fourth year students in a class A medical school. A postgraduate interneship of one year in psychiatry (psychiatric residents) is offered to graduates in medicine who have already served or are now serving in an accredited rotating interneship. Proof of completion of the interneship must be shown before entrance on duty. No written test is required and there are no age limits.

Revised requirements for public health nurses and graduate nurses for general staff duty have also been announced by the Civil Service Commission. Further information on any of these positions and proper application forms can be secured from the civil service officer at any first- or second-class post office.

CORRESPONDENCE

July 17, 1942

George B. Larson
Assistant Secretary
State Medical Society of Wisconsin
Madison, Wisconsin

Dear Mr. Larson: The Dodge County Medical Society wishes to express their appreciation to you and to the Committee on Health and Public Instruction for the assistance you gave us in making our educational exhibit at the local county fair possible.

We used the large panels with the paraphrased nursery rhymes printed on them as a background, and in the booth itself, we had numerous educational pamphlets for distribution and a portable fluoroscopic unit. The latter was furnished through the courtesy of the Milwaukee branch of the General Electric X-ray Corporation and by having people view their extremities through the screen, we were able to demonstrate to them one of the mechanical aids that physicians use in the course of diagnosis.

We arranged a schedule so that some member of the Society was always at the booth and although the attendance at our fair was below average this year, I feel that the exhibit was well worth while. The interest shown was very gratifying and it afforded a splendid opportunity for our physicians to render an educational service to the people of the county.

Sincerely yours,
E. Charles Hoyer, M. D.
Chairman of Exhibit Committee
Dodge County Medical Society

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The Journal Bookshelf

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

The Clarks: An American Phenomenon. By William D. Mangam, with introduction by E. A. Ross, professor of sociology, University of Wisconsin. Cloth. Price $2.50. Pp. 257. New York City: Silver Bow Press, 289 Fourth Avenue, 1941.

This book is entirely nonmedical in nature. It is an account of an American business family which was nationally known. It contains no medical references of interest. W. H. O.

Treatment of Diabetes Mellitus. By Elliott P. Joslin, A. M., M. D., Sc. D., medical director, George F. Baker Clinic, New England Deaconess Hospital; clinical professor of medicine emeritus, Harvard Medical School; consulting physician, Boston City Hospital. With Howard F. Root, M. D., instructor in medicine, Harvard Medical School; Priscilla White, M. D., instructor in pediatrics, Tufts College Medical School; and Alexander Marble, M. D., instructor in medicine, Harvard Medical School. Ed. 7, enlarged and thoroughly revised. Cloth. Price, $7.50 Pp. 783, illustrated. Philadelphia: Lea and Febiger, 1940.

This volume is a complete textbook of diabetes equally valuable to either the general practitioner or the specialist in diseases of metabolism. It is written by a group of clinicians who have probably had a wider experience in handling diabetic patients than any group in the country. Dr. Joslin is justifiably recognized as the "dean of American diabetic specialists." The collaboration of his three able coauthors has provided an even greater breadth of personal experience, so that the volume must be regarded as thoroughly authoritative as well as complete.

An additional sixteen-page chapter on "Allergy and Diabetes" has been added over the sixth edition, and the total text has been expanded by about seventy-five pages, chiefly in the section relating to diet and diabetes. Dr. Joslin has long been known as a proponent of moderate fat, moderate carbohydrate diets, which are not so far removed from those of normal individuals that the diabetic patient needs to feel that his disease is imposing any social stigma on him.

This volume may be heartily recommended with no reservation except to call attention to the innovations and variations in management of patients, as well as the great diversity of opinion concerning diet. These changes result from the constantly changing concepts of the physiology and pathology of the disease arising from our gradually growing body of knowledge of the endocrine and biochemical mechanisms involved in total metabolism. E. S. G.

Synopsis of Materia Medica, Toxicology, and Pharmacology. For students and practitioners of medicine. By Forrest Ramon Davison, B. A., M. Sc., Ph. D., M. B., Medical Department, The Upjohn Co., Kalamazoo, Mich., formerly assistant professor of pharmacology in the School of Medicine, University of Arkansas, Little Rock. Ed. 2. Cloth. Price $5.75. Pp. 695, with 45 illustrations, including 4 in color. St. Louis: The C. V. Mosby Company, 1942.

This synopsis of materia medica, toxicology and pharmacology is precisely as the title indicates. Should a reader wish definite evidences and an analytical discussion of action of drugs he will obviously have to consult appropriate treatises on the subject. Nevertheless, this synopsis should serve a useful rôle for those who wish to have available a brief résumé for quick reference purposes. A. L. T.

Electrotherapy and Light Therapy with the Essentials of Hydrotherapy and Mechanotherapy. By Richard Kovacs, M. D., professor of physical therapy, New York Polyclinic Medical School and Hospital; attending physical therapist, Manhattan State, Harlem Valley State and West Side Hospitals; visiting physical therapist, New York City Department of Correction Hospitals; consulting physical therapist, New York Infirmary for Women and Children, Mary Immaculate Hospital, Jamaica, N. Y., Hackensack Hospital, Hackensack, N. J., St. Charles Hospital, Port Jefferson, L. I. Ed. 4, thoroughly revised. Cloth. Price $8. Pp. 735, illustrated with 314 engravings and a color plate. Philadelphia: Lea & Febiger, 1942.

The fourth edition of Kovacs' "Electrotherapy and Light Therapy" within a decade may be taken as evidence of the usefulness of this authoritative volume to the practitioner and of the steady growth away from empiricism in this field of specialization. It includes recent advances in electrotonics, electrophysiology, iontherapy, and the electric shock treatment of mental diseases. The book is well documented, containing over 500 references. About 60 per cent of the volume is concerned with the more highly specialized branches of physical medicine which give the book its main title. The essentials of hydrotherapy and mechanotherapy are very lightly touched. The subject of exercise deserves more attention than it receives. The new edition is timely since physical therapy is destined to be an increasingly important tool in the armamentarium of the military surgeon. F. A. H.

Solving School Health Problems. By Dorothy B. Nyswander, Ph. D., director of The Astoria Demonstration Study, sponsored by Department of Health and Board of Education of New York City. Cloth. Price $2. Pp. 377. New York City: The Commonwealth Fund, 1942.

This book should be of value to the school administrator, the classroom teacher, and personnel in school health services such as physicians and nurses. While it is specifically a study of the Astoria school health program, the analytical steps

are given with such clarity that it could serve as a guide in any community where there is a desire to discover what the existing practices are, to face realistically limitations that must be accepted and to plan a better service. The Astoria demonstration indicated need for: 1. better defined objectives; 2. more emphasis on health education; 3. better coordination of efforts; 4. better cooperation with home and family physician; 5. willingness to experiment; 6. more opportunity for in-service growth of staff members. In short, "What is wrong with the school health service?" and "How can it be improved?" are questions that one school health service has answered for itself.

The quality and color of the paper is good. The type is easily read. Its organization lends itself to easy use. A summary of each chapter emphasizes the important points. The numerous forms developed for the study and for use in health service procedures, the tables which give findings of the study presented, and the exhibits in the appendix offer very tangible help for undertaking a similar study.

It would seem that in considering the total health of the child there might be included more specific mental health studies. Whether this area was not considered appropriate for inclusion or whether the omission was due to lack of staff in Astoria was not clear. It also seemed at times that the entire service was directed toward discovering and correcting defects with little emphasis on the health needs of the well child or the health assets of all children.

The need for staff participation in planning and executing a school health program was stressed. This is believed to be the best method for developing a school health program with maximum benefits to the child. P. P. C.

The Medical Clinics of North America. New York Number. Volume 26, Number 3. Cloth. Price $16 per clinic year. Pp. 645–995. Philadelphia and London: W. B. Saunders Company, May, 1942.

About two-thirds of this volume is devoted to a symposium on gastro-intestinal diseases. There are twenty different articles in this group, covering the newer developments in the field very adequately. The remaining third is devoted to a variety of subjects, but predominantly circulatory diseases. The paper by De Graff and Batterman on "Recent Advances in Digitalis Therapy with Particular Attention to the Use of Pure Glycosides" is particularly timely in view of the changes in digitalis standardization in U. S. Pharmacopoeias XI and XII and the confusion among many clinicians which has resulted.

M. L. C.

Neuroanatomy: By Fred A. Mettler, A. M., M. D., Ph. D., professor of anatomy, University of Georgia School of Medicine, Augusta, Georgia. Cloth. Price $7.50. Pp. 476, with 337 illustrations including 30 in color. St. Louis: The C. V. Mosby Company, 1942.

Superficial examination of this new addition to neuro-anatomy textbooks gives a reviewer a very

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BOOK REVIEWS—Continued

favorable impression. The paper is of good quality, the type is clear, names of structures are in boldface type, and the illustrations are exceedingly well done. The diagrams of the cranial nerves, in which the components are depicted by colored lines, are clear and useful. A very complete series of illustrations of Weigert sections and corresponding Nissl series are unusually good.

Detailed examination, however, reveals a number of defects, the most conspicuous of which are lack of organization of the subject matter; omission of an organized, systematic presentation and analysis of nerve components; no mention and explanation of the fundamental brain stem; the very abbreviated account of the embryology of the nervous system; and the placement of the diagrams with reference to the text.

Lack of organization is particularly striking in chapters VI and XIII. In chapter VI, "Interior of the Hemispheres," no distinction is drawn between the brain stem and the cerebral hemispheres. Internal structure of the hemispheres, cerebrospinal fluid, epithalamus, and the olfactory system are presented with little or no break in continuity. On page 147, the transition from a discussion of the cerebrospinal fluid to that of the epithalamus occurs without any particular indication, and on page 148, this passes into an account of the olfactory system. On page 153, the external surface of the midbrain is described. In chapter XIII, "The Mesencephalon," page 275, there occurs a "Summary of the Region of the Pons." In the same chapter are included audition, with a description of the labyrinth; vestibular function; cerebellar mechanisms; and the fifth nerve.

On page 77, under the diagram of the facial nerve one reads, "Red, somatic motor fibers; blue, sensory fibers (all types); green, parasympathetic motor fibers (all types); those in motor root are destined for sweat glands, innervated by distal part of nerve." Instead of somatic motor should be special visceral motor; not all types of sensory fibers are present in the facial; and the facial is not a nerve to sweat glands.

Other errors are not numerous. On page 27, "The vertebral artery enters the subarachnoid space through the first intervertebral foramen." On page 72, "The olfactory tract forms the first cranial nerve."

In the brief section on the autonomic system, there is much confusion for the beginning student. On page 86, "The term autonomic nervous system is an inclusive one applied to all the nerves, ganglia and plexuses which deal with the motor innervation of smooth muscles and glandular tissues throughout the body." But, on page 87, this is confused by "It consists mainly of motor fibers to the viscera, although some sensory fibers are found in it. These sensory fibers, by definition, do not belong to the autonomic system." On page 88, is a diagram of the autonomic system. On page 89, is a "Diagram of the sensory fibers traveling with and within the autonomic pathways. Green, afferent fibers ending in medulla; red, those ending in the spinal cord. The blue group is not an autonomic element. It represents the afferent fibers of the phrenic nerve. For the sensory supply of the tongue see fig. 55."

A rather amusing sentence occurs on page 145: "If the pressure of the cerebrospinal fluid rises above the arterial blood pressure, no blood can enter the brain case and severe symptoms occur, due to anemia of the neural system."

In the chapter on general gross features of transverse sections of the medulla and the pons, the illustrations are entirely foreign to the text, they being coronal sections through the entire brain and showing little or nothing relative to the descriptive material. Reference is given, however, to appropriate figures which occur farther along in the book. F. D. G.

Essentials of Dermatology. By Norman Tobias, M. D., senior instructor in dermatology, St. Louis University; assistant dermatologist, Firmin Desloge and St. Mary's Hospitals; visiting dermatologist, St. Louis City Sanitarium and Isolation Hospital. Cloth. Price, $4.75. Pp. 497, illustrated. Philadelphia: J. B. Lippincott Company, 1941.

This book of 480 pages is a concise treatise on diseases of the skin. It is a book written for practitioners of general medicine and medical students. It is so condensed as to give the essential picture of each skin disease in as few words as possible, and still present the necessary information to aid in the diagnosis and differential diagnosis. The book is divided into thirty-two sections, which are made up of the usual classifications dividing the various skin diseases into their etiologic and class groups. For so small a book it is unusually well illustrated with excellent photographs. The section on syphilis is well done, and there is a treatment plan outlined for each stage of syphilis.

A brief outline of treatment is given for each of the various diseases. This is made very practical and does not include technics which are reserved for the specialist.

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The encyclopedic nature of this book makes it an excellent textbook. For the last year it has been used satisfactorily in teaching dermatology to medical students and as a reference book for nurses. The organization of the book gives cross references to other, but similar, conditions. This book is extremely practical and, therefore, should be of great value to the general practitioner. G. A. C.

Dermatologic Therapy in General Practice. By Marion B. Sulzberger, M. D., Lt. Comdr. (M. C.) U. S. N. R., assistant clinical professor of dermatology and syphilology, Skin and Cancer Unit of the New York Post-Graduate Medical School and Hospital of Columbia University; associate attending dermatologist, Montefiore Hospital, New York City; and Jack Wolf, M. D., attending dermatologist and syphilologist, Skin and Cancer Unit of the New York Post-Graduate Medical School and Hospital of Columbia University; director of dermatology, New York City Cancer Institute. Ed. 2, revised and completely reset, 1942. Cloth. Price $5. Pp. 632. Chicago: The Year Book Publishers, Inc.

About one year ago, the first edition of this book was reviewed. In this short time, the printing has been entirely exhausted, and a new revised edition has been published.

Notable changes in the second edition are: an expansion of the index which makes for a more ready cross indexing of the information; the addition of the use of sulfonamides in dermatology; and the treatment of skin damage caused by poison gas. The book is prepared also, at this time, as a help to Army and Navy medical officers, who will be dealing with dermatologic conditions.

The fact that a second edition and reprinting were required within a year of its original publication should be sufficient evidence of the value and practicality of the book. G. A. C.

Diseases of Metabolism: Detailed Methods of Diagnosis and Treatment. A Text for the Practitioner. Edited by Garfield G. Duncan, M. D., chief of Medical Service "B," Pennsylvania Hospital; associate professor of medicine, Jefferson Medical College, Philadelphia. Cloth. Price $12. Pp. 985, with 158 illustrations including 7 plates in color. Philadelphia: W. B. Saunders Company, 1942.

A very satisfactory description of this book is provided by the introduction which was prepared by the late Dr. Frederick D. Banting:

"During the past few decades the clinician and the laboratory worker have been drawn closer together, to the mutual benefit of each. This symbiosis has stimulated research. There has been an increasing flow of new facts. These facts have led to a better understanding of both the normal and the abnormal. There are few branches of medical science in which sound knowledge has advanced so rapidly as has been the case in the field of the diseases of metabolism.

"Metabolism can be treated as an entity in a laboratory but, in dealing with diseases of metabolism, it is found necessary to invade the fields of nutrition, endocrinology and even hematology. The purpose of this book is to present the fundamental knowledge of metabolism, to apply this knowledge

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to the explanation of diseases of metabolism and to outline a rational basis for the treatment of these diseases.

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The book is prepared by fourteen outstanding authors, who have collaborated with Duncan, and the latter has been responsible for about one-third of this volume. It is up-to-date, reads well and can be recommended as a very satisfactory reference book in the field of the diseases of metabolism. E. L. S.

The Medical Clinics of North America. St. Louis Number, Vol. 26, No. 2. Cloth. Price $16 per clinic year. Pp. 644, with 126 illustrations. Philadelphia: W. B. Saunders Company, March, 1942.

Approximately two-thirds of this volume are devoted to a symposium on medical emergencies. This portion includes a wide variety of material as is evident from some of the titles of different chapters. For example, there are good discussions of cardiac, renal, vascular, gastro-intestinal and diabetic emergencies; the management of psychoses and alcoholism in general practice; the management of acute poisonings; treatment of fractures and of obstetrical emergencies associated with hemorrhage, etc. The last third is devoted to a symposium on tuberculosis. The usual standard of these clinics is well maintained in this St. Louis number. In addition, this volume may have more than the usual appeal as sound articles on the treatment of emergencies have a particular interest to most physicians. M. L. C.

Memorable Days in Medicine. A calendar of biology and medicine. By Paul F. and Alice Schiedt Clark, Department of Bacteriology of the University of Wisconsin Medical School. Cloth. Price $2. Pp. 305. Madison: The University of Wisconsin Press, 1942.

"Memorable Days in Medicine" is a calendar for the historically minded student of biology and medicine. It may also be said that reading it will do a good deal to develop the historical mind. Each day of the year has one or more interesting notations about some medical character or scientific event. The selections have been made with particular care. The book is nicely printed, generously illustrated, and well indexed. The volume makes very entertaining reading, and it is worthy of a place in any library. W. J. M.

Management of the Sick Infant and Child. By Langley Porter, B. S., M. D., M. R. C. S. (Eng.), L. R. C. P. (Lond.), dean emeritus, University of California Medical School and professor of medicine; formerly professor of clinical pediatrics, University of California Medical School; formerly visiting pediatrician, San Francisco Children's Hospital; formerly member Health Advisory Board of the City and County of San Francisco, and William E. Carter, M. D., director of University of California Hospital, Out-Patient Department; formerly chief of Children's Clinic, University of California Hospital; formerly attending physician, Los Angeles County Hospital; formerly attending physician, San Francisco Hospital, San Francisco. Ed. 6, revised. Cloth. Price $11.50. Pp. 977. St. Louis: The C. V. Mosby Company, 1942.

In bringing it up to date so much new material has been added to the sixth edition of Porter and Carter as to enlarge it over the previous edition by more than 100 pages. The entire text has been subjected to thorough revision, the most extensive changes having been made in the chapters on nutrition, convulsions, prematurity, diseases of the respiratory tract and internal secretions.

The subject matter is divided into three parts. In the first part, which consists of 178 pages, health and diseases of infants and children are considered under the chapter headings of general considerations, vomiting, diarrhea, constipation, nutrition, hemorrhage, pain and tenderness, convulsions, fever, cough and prematurity. The second part, which takes up 462 pages, is devoted to specific diseases of the various systems of the body. The third part, 286 pages in length, is concerned with methods (diagnostic and therapeutic procedures), formulas and recipes for the sick and the well, sample prescriptions for many different diseases, and the treatment of poisoning.

A popular book since its introduction in 1922, the present edition maintains, and even enhances, the excellent reputation established by its predecessors. Written in a graceful style which makes it one of the most readable of textbooks, it expresses the current concepts of the best approaches to clinical pediatrics. Valuable for undergraduate students, the book is so practical in the treatment of its subject that its most appreciative readers will be those who are actually engaged in the care of sick infants and children. J. E. G.

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THE PRESS

With America becoming more conscious of the importance of vitamin and food value daily there should be great interest in a supplement to the Wisconsin Medical Journal sent out by the State Medical Society of Wisconsin called Health and Food.

The supplement contains articles by authorities in various fields on the value of different foods in the diet, and butter and dairy products are rated among the first in importance.

The state is first in milk production, milk cows, all cheese, peas for canning. Second in the production of beets, cucumbers, cranberries and late cabbage. Third in creamery butter, snap beans and sweet corn, and also famous for one to two million bushels of apples, 285,000 crates of strawberries, 15,000 tons of cherries, 14,000,000 bushels of potatoes, for maple syrup and honey.

Wisconsin is one of the three healthiest states in the Union. It is extremely probable that the high dairy product content in the average Wisconsin diet has a good deal to do with the fine health record of the state. Professor E. B. Hart, chairman of the section of Biochemistry, University of Wisconsin, says that if you had to choose a single food on which to live for the rest of your life, your wisest possible choice would be milk. Milk, he says, is the only food which, without any help from other foods, could give you a well rounded, healthful diet. This is good advice for all of us in the heart of the dairy section of Wisconsin to follow. We must guard our health carefully in these days, for we want to be in a position to do our best work when it is so vital for the future of our country for us to do so.

Among the "health achievements in Wisconsin" listed in the supplement is the statement that hospital facilities are within thirty miles of anyone in Wisconsin, with the further statement that in 1890 the average patient stayed in hospitals 28 days, in 1915 this was brought down to 22, and that now it is less than nine days. Since 1910 nineteen years have been added to the average span of life. Typhoid fever claims fewer lives in Wisconsin than in any other state in the nation.

Both mothers and babies are safer here, and far fewer are lost through childbirth than in Europe. Communicable diseases including smallpox and diphtheria have been controlled and now are comparatively rare throughout the state.

All in all, "Health and Food" gives us a lot more reasons to be thankful for living in one of the finest states in the union, and somehow it seems particularly fitting to us that the vacationland of the United States, our Wisconsin with its beautiful out of doors, should likewise be one of the healthiest places in which to live.

* Reprinted from *The Sheboygan Press*, June 24, 1942.

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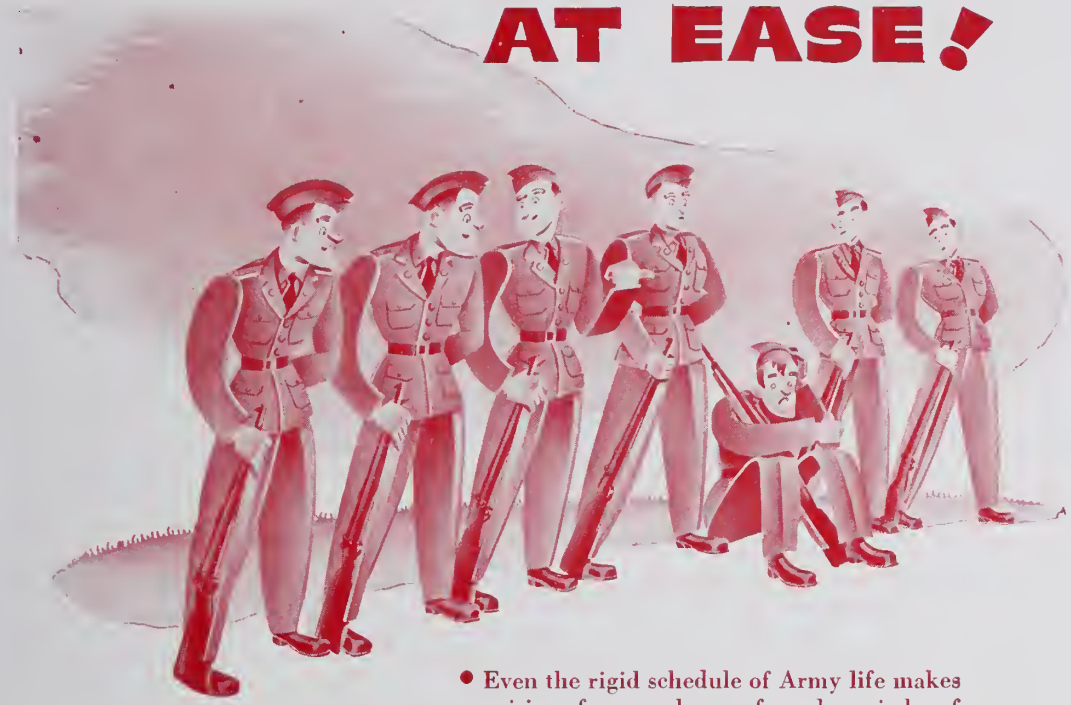

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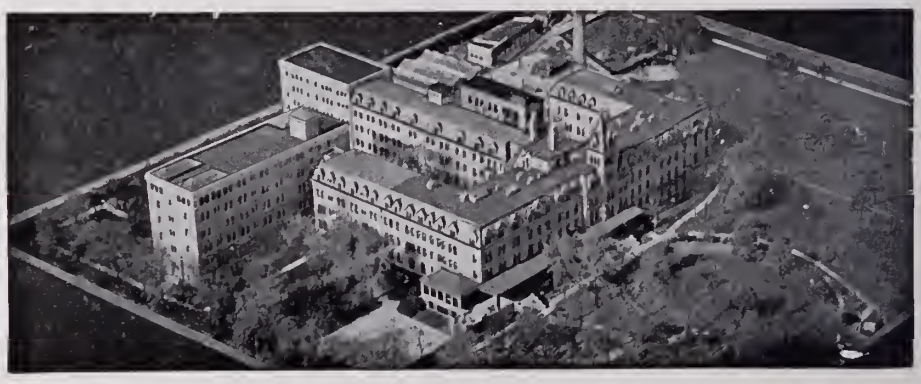
[Entered as second class matter, June 30th, 1903, at the Post Office at Milwaukee, Wis., under Act of Congress March 3rd, 1879. Transferred to Madison, Aug. 1st, 1929.]
"Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized Aug. 7, 1918."



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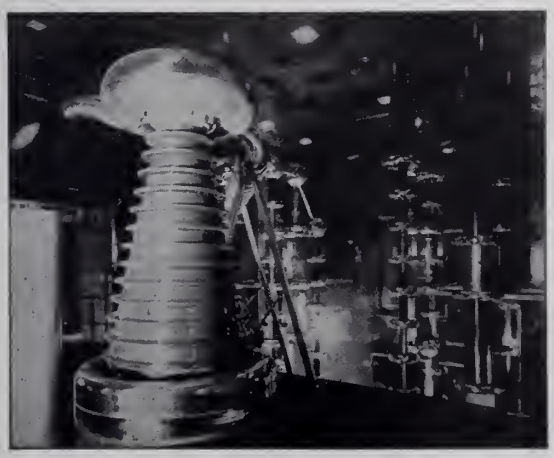

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1. McEachern, D.: *Canadian Med. Ass'n. J.*, 45:106, 1941.
2. Lennox, W. G.: *Med. Ann. Dist. Col.*, 10:461, 1941.

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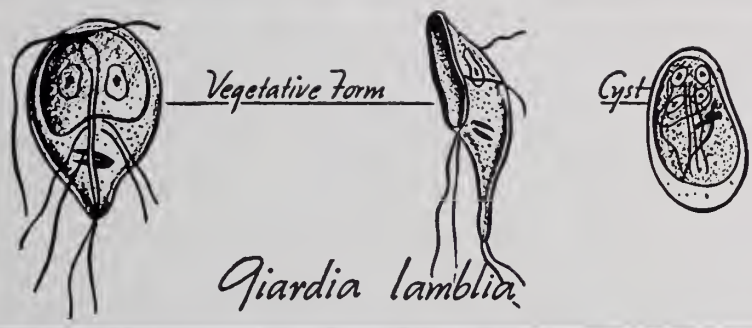

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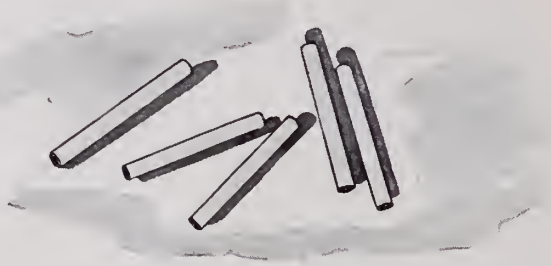

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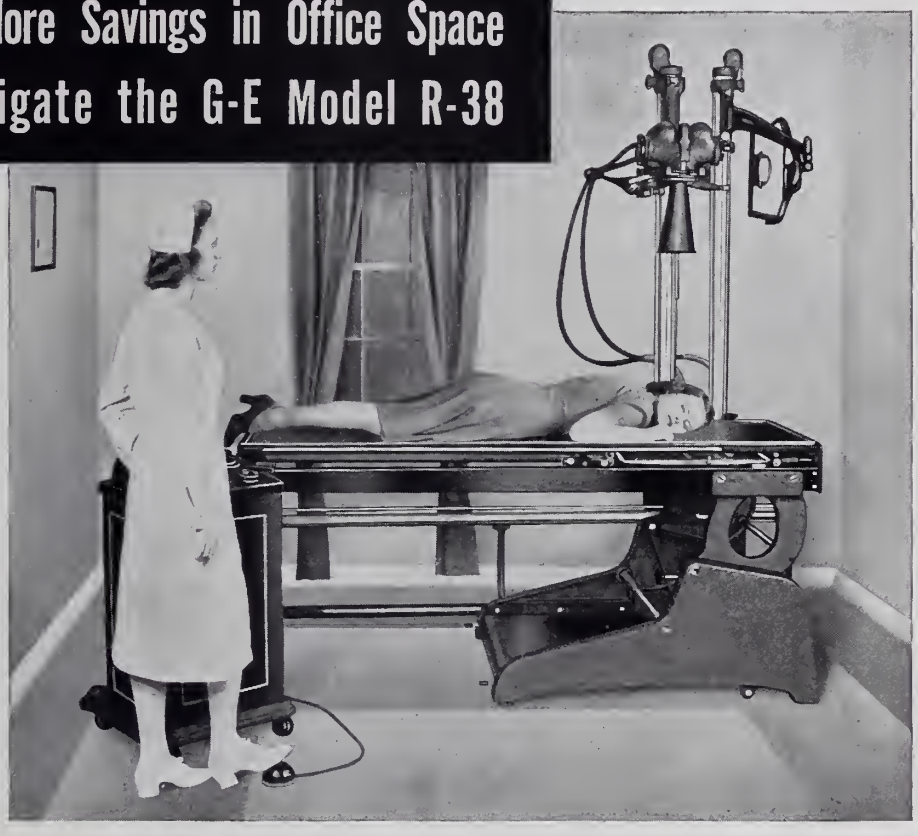

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THE WISCONSIN MEDICAL JOURNAL

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Serial Curves in Coronary Occlusion

By J. BAILEY CARTER, M. D.*
Chicago

IN general arteriosclerosis is a progressive lesion. Coronary disease is no exception to the rule. Likewise, thrombosis with infarction reveals this tendency to progression. A mild attack often precedes a major occlusion, or there may be a series of mild attacks. Again, the process of organization within the area of infarction results in graphic alterations which change from day to day. It is from this characteristic that serial curves derive their importance.

That the characteristic electrocardiographic changes following experimental myocardial infarction are of a progressive nature was shown in 1909 by Eppinger and Rothberger,[1] who produced an acute destruction of tissue by the injection of silver nitrate into certain areas of the myocardium. In 1910 Samojloff[2] reported similar observations. The classic experiments of Smith[3] in 1918 were confirmatory. Numerous clinical observations have confirmed this feature of myocardial infarction. By the very title of their article, some authors[4, 5] declare that the picture is not fixed. All this has been pointed out by Herrick,[6] who states, "One feature needs repetition lest it be forgotten. It is that the electrocardiogram in these cases of acute myocardial destruction is not fixed, that for a long time it undergoes change."

The importance of serial curves in coronary occlusion has been emphasized by Cooksey and Freund[7] and by others.[8, 9] Not all authors, and by no means all clinicians, recognize the fact that the electrocardiograph registers the destructive and reparative changes associated with infarct organization, that it should and does reveal variations from day to day and that these changes are diagnostic of coronary occlusion in the majority of instances.

Important in Diagnosis

Few recent reports[10] sufficiently emphasize the diagnostic importance of serial curves in coronary occlusion. They are often useful, at times essential, for accurate diagnosis. They are of assistance in following the process of infarct organization and in estimating the rate and degree of healing in the infarcted area; and finally, they help to determine the residual coronary insufficiency that remains after healing has ceased.

It is difficult to obtain a sufficiently large individual series to study in detail the progressive changes following an infarction. Often, the initial record, for various reasons, is not obtained immediately after the acute attack. Again, records at sufficiently frequent intervals may not be feasible in many instances. Finally, during the stage of recovery, similar difficulties may be experienced for other reasons. Furthermore, no one series actually shows all the typical changes.

Series Differ

Obviously, differences will exist between series from different cases. Variations in the extent of myocardial involvement and the wide differences in recuperative power of the coronary circulation of different hearts result in marked variations in serial curves from different cases of myocardial infarction. Likewise, time relations of corresponding stages vary widely, depending on the individual case. Again, the tempo of the changes in one lead is not always that of the

* Assistant clinical professor, Department of Medicine, Rush Medical College of the University of Chicago.

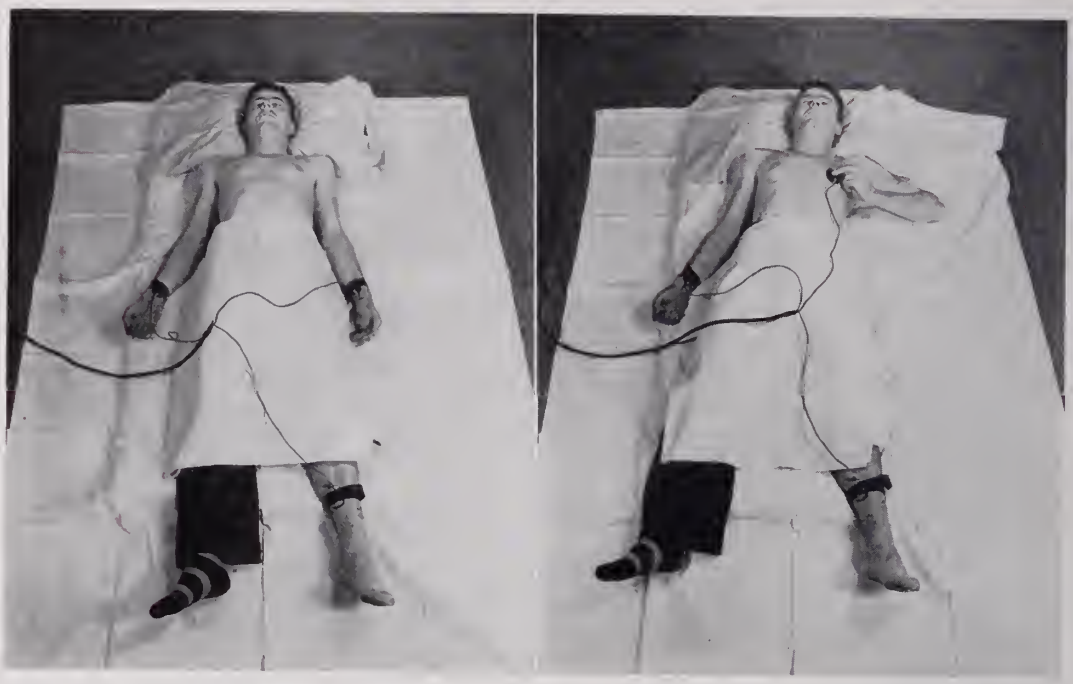

Fig. 1. (A) Routine technic for recording limb leads. (B) Simplified technic for recording chest leads.

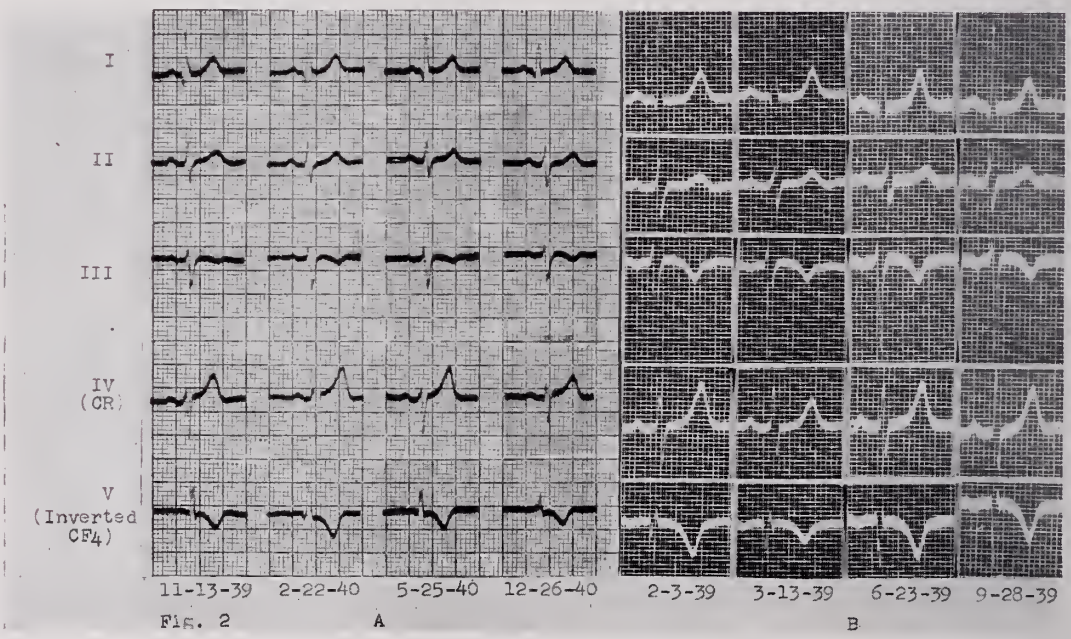

Fig. 2. Serial curves to rule out coronary occlusion. It is important that the technic employed permit duplication of chest leads.[11] The technic described does this in most instances. It is frequently of great diagnostic assistance. Likewise, if it is recognized that the technic used permits such routine duplication of chest leads, then minor variations, otherwise undependable, assume diagnostic significance.

(A) Male, age 44. Sudden attack closely simulating an occlusion clinically. In spite of absent Q_5 no history of a previous similar attack could be obtained.

(B) Female, age 59. A severe anginal attack so closely simulated occlusion that the physician insisted on serial curves.

corresponding changes in the reciprocal lead or in lead 2. Obviously, the record is not normal in all cases at first nor does it in all cases return to its pre-existing level or to normal. To appreciate the extent to which serial curves vary individually and from the classic type, many serial records from different cases of coronary occlusion must be carefully studied.

Study Made

During a five year period, 4,351 graphs were recorded on 3,879 private patients referred for electrocardiographic examination. From this group 668 records, representing 350 coronary occlusions in 345 patients, were selected for study. Graphic abnormalities indicative of recent infarction were the sole basis for selection. Only patients with definite electrocardiographic evidence of occlusion in the initial record or in subsequent curves were included.[11-14]

The patient was always in the recumbent position.[15, 16] The three limb leads were recorded first. Chest leads were obtained by transferring the left arm electrode to the left fifth interspace at the midclavicular line, lead wire connections remaining undisturbed.[11] On the control board, lead 1 and lead 3 were selected in succession, a right arm to precordium (CR_4) and a standard lead 5 (inverted CF_4) chest lead being thereby recorded.[17]

In addition to a number of instances in which serial curves were helpful or confirmatory, they were essential for diagnosis in 18 of the 350 cases of coronary occlusion.

Immediately after an attack of coronary occlusion the characteristic limb lead change is the striking S–T interval displacement.

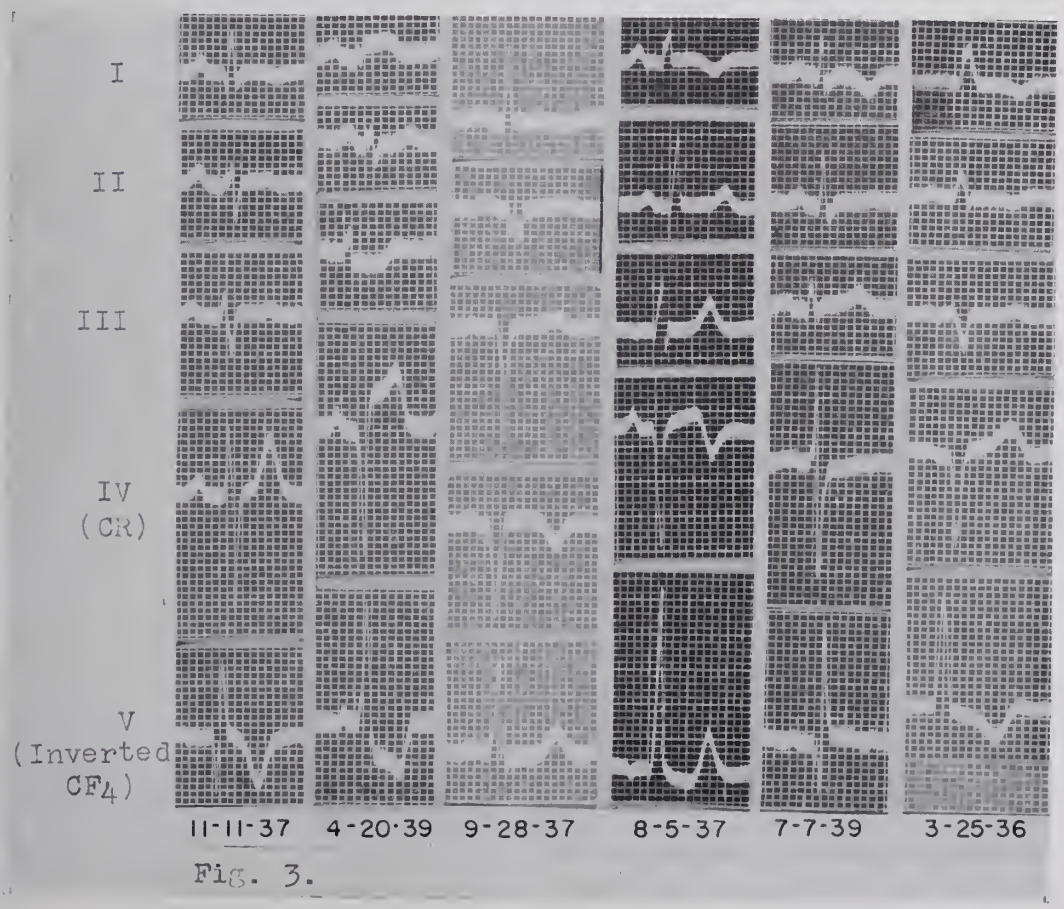

Fig. 3. Various T_1 occlusion curves following anterior apical infarctions.

Although this change predominates early, it usually disappears rapidly, often in a few hours or days. The S–T interval displacement is most transitory with lateral infarction. With either anterior or posterior infarction it may persist for as long as twenty-one days. With anterior infarction, displacement of the S–T interval in chest leads persists longer than in limb leads. Occasionally it is of assistance in directing attention to the recent occurrence of an occlusion and in this way may be of assistance in diagnosis. With posterior infarction, S–T interval displacement is much more transitory in chest leads than in limb leads. Although present, the S–T interval displacement here is so transitory that unless the graph is recorded immediately after the onset of an occlusion, the change is frequently missed. With posterior infarctions, persistence of S–T interval displacement in the limb leads is of much greater assistance in diagnosis.

Anterior Infarction

During the early stage of an acute myocardial infarction involving the anterior apical portion of the left ventricle, there is elevation of the S–T interval in lead 1. The descending limb of the R wave does not return to the iso-electric level but passes into this elevated S–T interval which is bowed upward and ends in a rounded shoulder at the beginning of the T wave. When this segment arises at or near the apex of the R wave, the ventricular complex becomes a

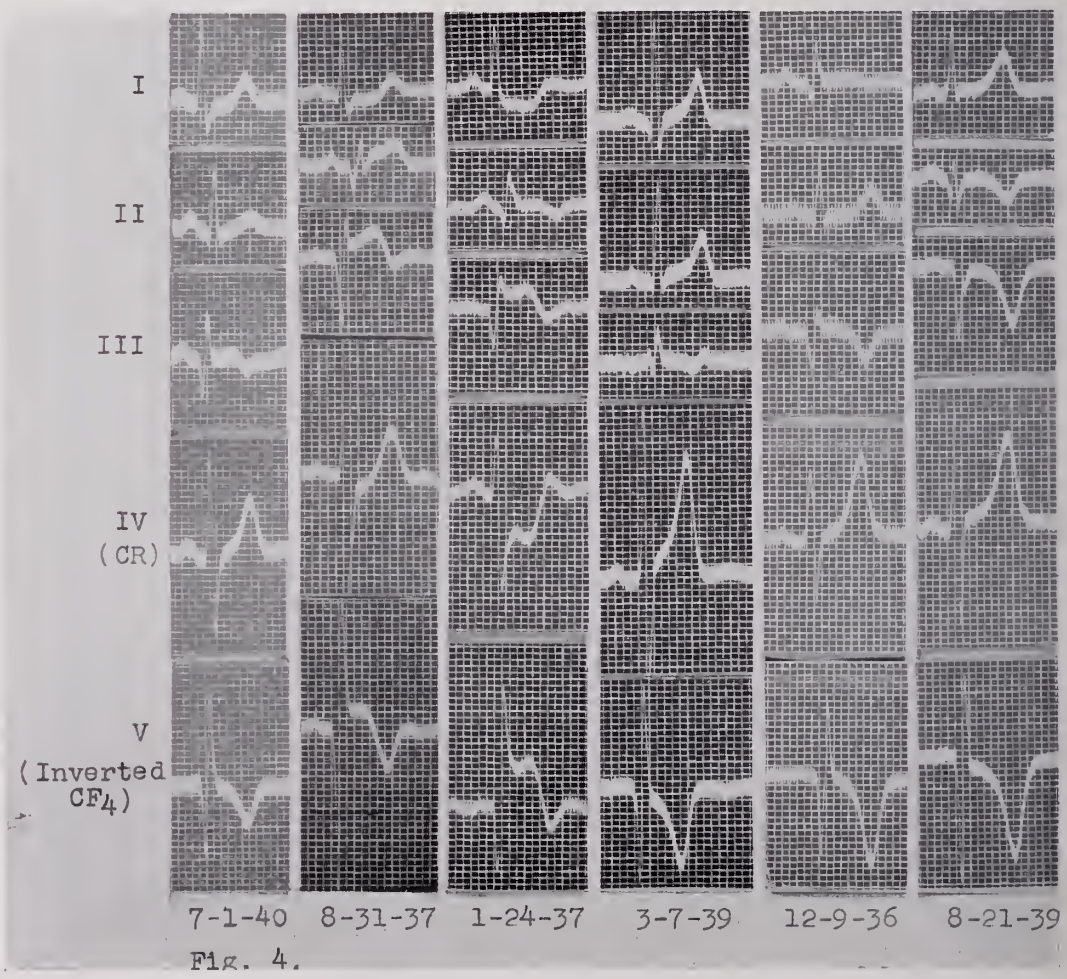

Fig. 4. Various Q_3T_3 occlusion curves following posterior basal infarctions.

monophasic curve, the T wave being merged in this highly arched S–T interval. This constitutes the "high take-off" of the terminal deflection from the initial complex. Owing to their reciprocal relationship, changes opposite to those described for lead 1 may occur in lead 3. These consist of a low take-off of the S–T interval from the ascending limb of the S wave, the S–T interval appearing depressed and presenting an inverted mirror image of the change in lead 1. The S–T interval usually ends in a slightly positive T wave rather than presenting a ventricular complex of monophasic type. Occasionally a Q_1 appears. At this stage S–T_4 becomes elevated, S–T_5 depressed and often horizontal, with T_{4-5} becoming more or less invisible. Likewise, at this time R_4 and Q_5 disappear.

Posterior Infarction

With posterior infarction, changes in leads 1 and 3 are the reverse of those with anterior infarction, i.e., S–T_3 elevation with S–T_1 depression. Here the S–T interval in lead 3 arises from the descending limb of the R wave, follows a slightly convex or plateau-like elevation and returns to the isoelectric level at the point of subsequent origin of the negative coronary T wave, a monophasic curve being inscribed. A similar, but less marked, elevation of the S–T

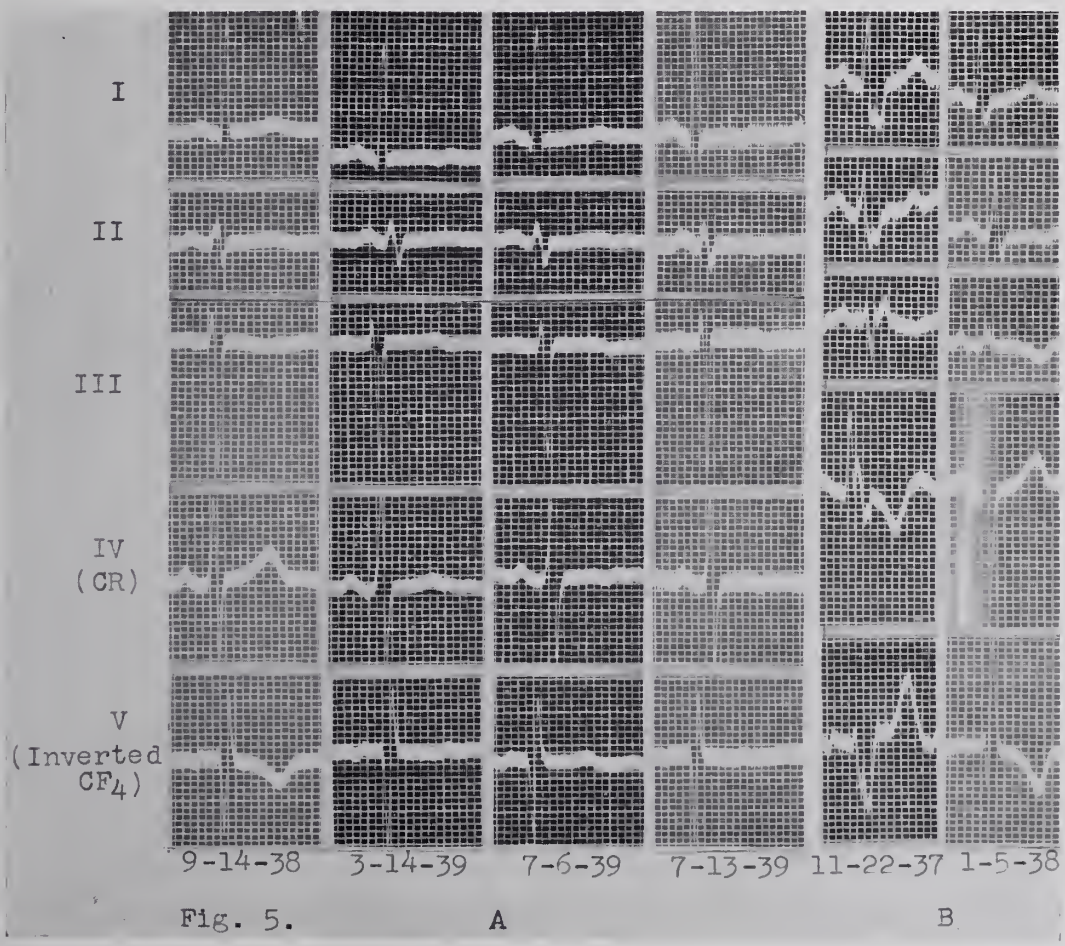

Fig. 5. (A) Serial curves representing a case of chronic coronary insufficiency with transitory acute episodes. Each curve was preceded by a severe anginal attack.

(B) Although the characteristics of the initial electrocardiogram are due primarily to transitory block, the contour of T_{2-3} in the subsequent record suggests that the attack was coronary occlusion rather than severe angina.

interval usually occurs in lead 2. The reciprocal low take-off from the ascending limb of the S wave results in a depression of the S–T interval in lead 1 which usually ends in an upright T wave, which, although of low amplitude, distinguishes the depressed S–T interval of infarction from one due to chronic coronary disease with or without associated arterial hypertension. This reciprocal change usually presents an inverted mirror image of the corresponding changes in lead 3, except that occasionally it is less marked and rarely absent.

During the very early stage following a posterior infarction, S–T_4 elevation and S–T_5 depression develop. The S–T interval displacement in this instance is less marked than is the corresponding change with anterior infarction. It is so transitory that, in most instances, it is missed, the contour of the chest leads appearing normal.

An associated Q_3 is frequent, due to its common occurrence with coronary sclerosis, with other disease of the left ventricle and with normal hearts. Rarely, if previously absent, does a deep Q_3 appear following infarction. Although a large Q_3 is commonly associated with the inverted T_3 of posterior infarction, such a combination alone does not constitute dependable evidence of an old infarction as does occasionally a similarly associated Q wave in lead 1.

In Limb Leads

Hence, we see that in limb leads the S–T interval displacement progressively diminishes and tends to return to the iso-electric level. This transitory change, most rapid with lateral infarction, is usually complete in three weeks with anterior and posterior infarction. Occasionally, it may be further delayed in cases of posterior infarction.

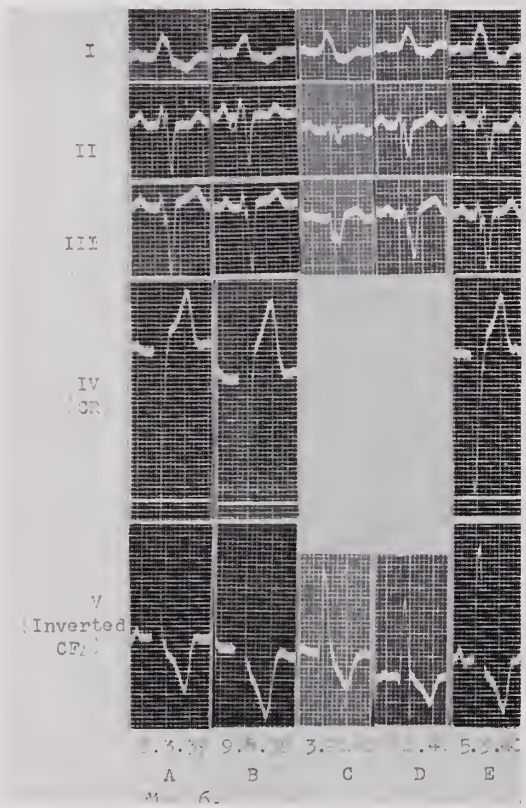

Fig. 6. Anterior infarction occurred one year previous to A. An acute anginal attack occurred on March 16, 1940. Contour of C suggests associated myocardial infarction. Death occurred May 25, 1940 following a similar, more severe, attack.

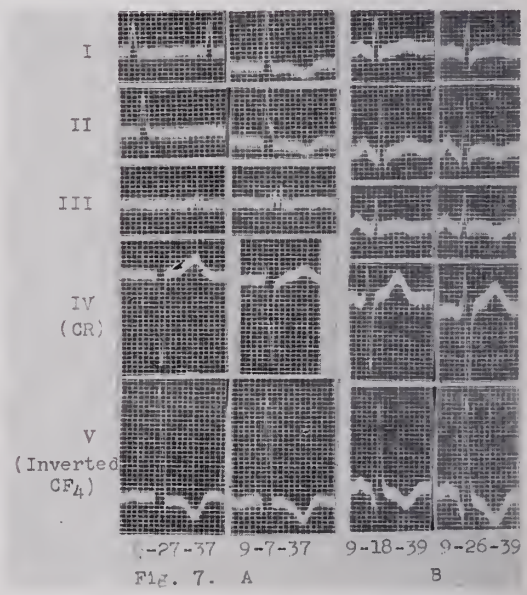

Fig. 7. Serial curves of anterior apical and posterior basal infarctions.

(A) Diagnosis of infarction from absent R_4 and Q_5 was confirmed by limb lead changes in the subsequent record.

(B) The contour of the slightly inverted T_3 suggested the infarction, confirmed by subsequent record. Shouldering of an inverted T_3 has repeatedly been of diagnostic assistance.

During this transition the S–T interval loses its characteristic bowing and a typically peaked coronary T wave appears with symmetrical limbs and rounded shoulders and directly opposite with regard to the original S–T interval displacement in the corresponding lead. With anterior infarction, as T_1 increases in depth and sharpness, T_3 increases in height and distinctness, a purely reciprocal change. With posterior infarction these changes are the reverse. At times, S–T_1 may be only slightly elevated or arise from the iso-electric level. Displacement of S–T_3 likewise is slight or absent. Hence, a negative coronary T wave, less common and striking, may occur in serial curves and be of assistance in diagnosis.

Rarely, characteristic T wave changes, associated with minor or absent S–T interval displacement, develop late following an acute occlusion, usually with anterior rather than posterior infarctions. If a previously normal record or subsequent graphs are available for comparison, serial curves may be of great assistance in such instances. A negative coronary T_1, arising from an iso-electric S–T interval, may represent the only remaining evidence of an old anterior infarction. A similar T wave which originated from a depressed S–T interval does not usually indicate previous infarction but more commonly chronic, sclerotic disease of the left ventricle. A negative T_3 of coronary contour, even when associated with a deep

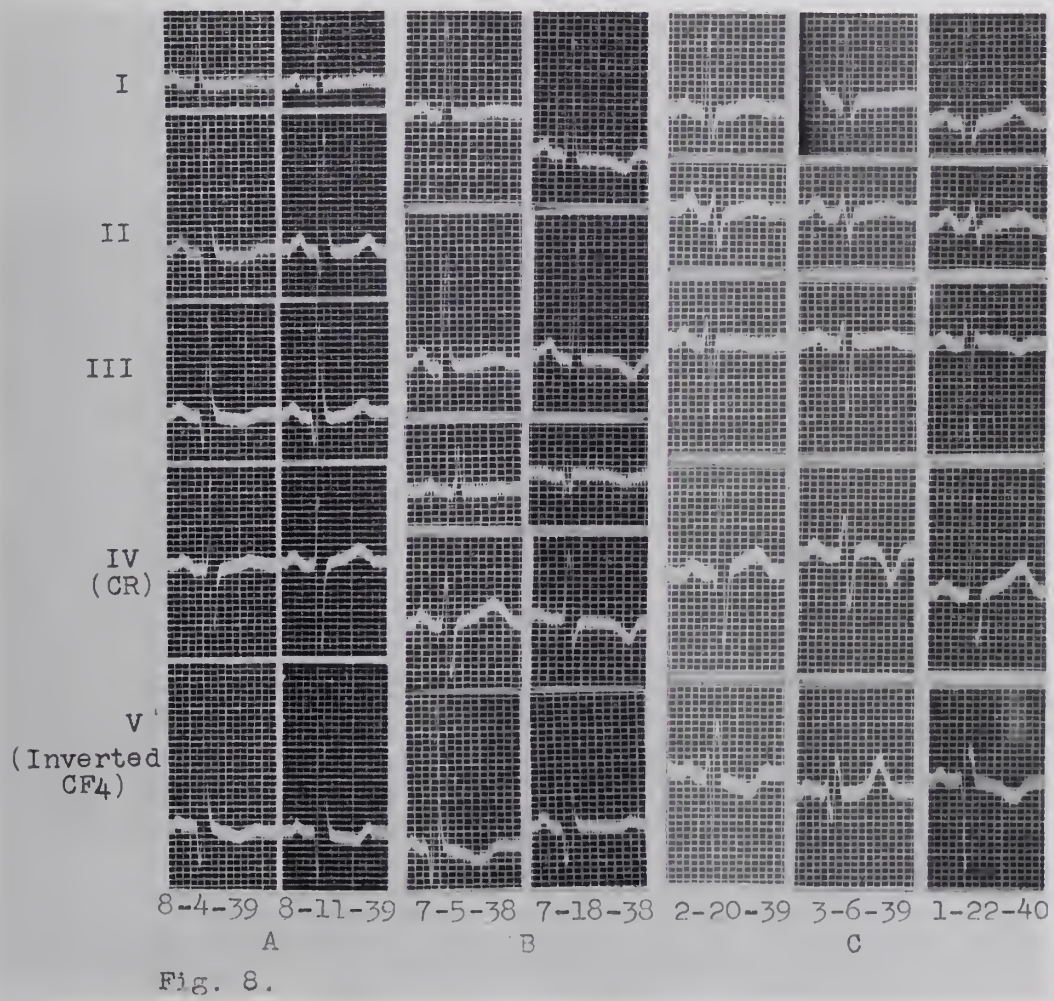

Fig. 8. Instances in which serial curves were essential for the diagnosis of coronary occlusion.

Q_3, does not constitute dependable evidence of an old posterior infarction unless an inverted T_2 of coronary contour is associated. Coronary T waves arising from an isoelectric S–T interval in leads 2 and 3 furnish reliable evidence of an old basal infarction in most instances. Seldom is it safe, in the presence of these findings, to exclude the possibility of an occlusion or to decide that the abnormality is due to one of several other conditions known to confuse the graphic picture of infarction without the benefit of serial electrocardiograms. At times low amplitude of all deflections in lead 1 may mask minor diagnostic alterations. Rarely, typical chest lead changes may precede dependable limb lead changes and assist in early diagnosis.

As stated elsewhere, consideration of T_1 and T_3 patterns, occasionally assisted by an associated Q_1 or Q_3, affords the greatest information regarding the occurrence of a recent occlusion. Particularly is this true if serial curves are available. Rarely, in the absence of dependably characteristic limb lead changes of infarction, chest leads may assist in establishing an early diagnosis without awaiting diagnostic serial changes.

Rarely, a clearly recognizable Q_1 may persist and dependably indicate an ancient anterior infarction after other diagnostic features have disappeared. Similar dependence on a persistent Q_3, even when associated with a negative T_3 of normal contour, is not justifiable in the absence of a coronary type of T wave in lead 2.

Graphic Localization

It has been pointed out[18] that some question the dependability of graphic localization of myocardial infarction.[19-22] That such localization is accurate in the majority of instances has been satisfactorily established.[23] It is true that the graphic diagnosis of multiple infarction, combined or in sequence, may be difficult at times. Usually, however,

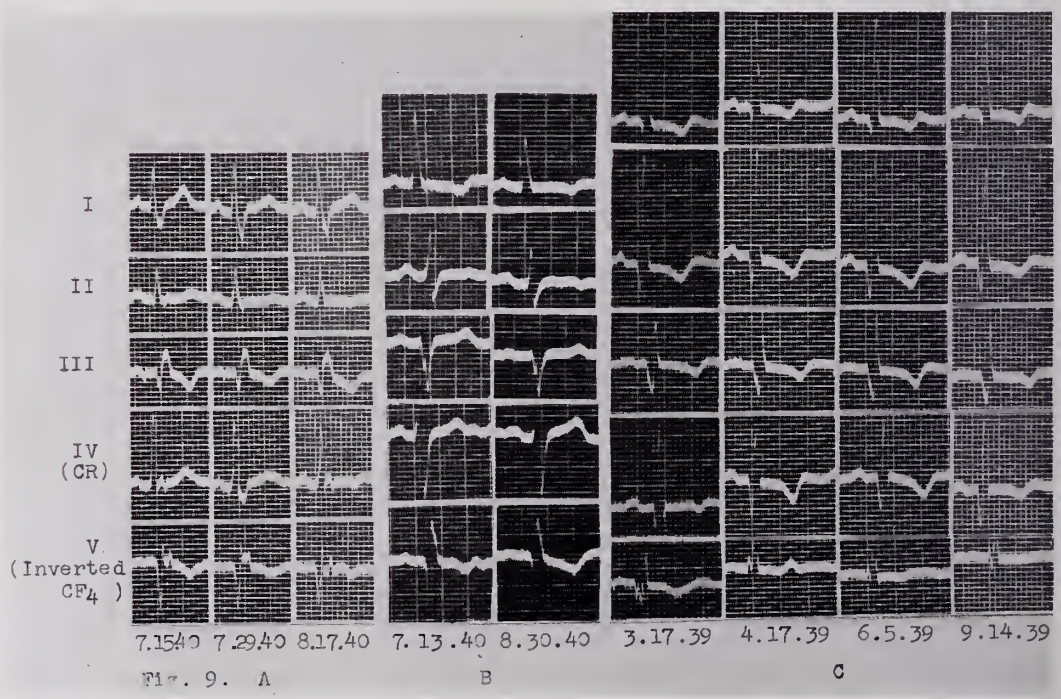

Fig. 9. Other instances where serial curves were essential for diagnosis.
(A) Male, age 51. B. P. before 170/100, immediately after 90/40 and 130/90 eight hours after attack. Leukocytes 12,800. Temperature 99.8 F.
(B) Graphic changes of infarction in a male, age 53, with arterial hypertension.
(C) Graphic changes of infarction masked by those of arterial hypertension in a physician, age 53, with many subsequent records, and in practice.

alterations resulting from the more recent occlusion dominate the picture. It must be admitted that occasionally the site of infarction cannot be determined by limb leads alone. At present, with the additional assistance of chest leads, and particularly serial curves, combined with the knowledge available, the diagnosis of recent occlusion with localization of the area of infarction can be established in most instances. Failure of the characteristic electrocardiographic changes of infarction to develop can usually be attributed[18] to the fact that tracings were not obtained in sufficient number or at proper intervals following the infarction, that multiple infarctions were present, or that bundle branch block[24–26] or pericarditis[27–31] obscured or modified the graphic changes of infarction.

Diagnostic changes may be missed if a single electrocardiogram is recorded too soon after an acute coronary occlusion.[32] An established arterial hypertension may also modify the form of the electrocardiogram and cause confusion in diagnosis.[9, 33, 34] Pulmonary embolism,[35–38] aortic aneurysm,[39–41] external chest trauma,[10] coronary insufficiency,[42] angina, congestive failure, and digitalis,[43–46] may, likewise, cause confusion in diagnosis. Whereas a single record following a coronary accident may not be diagnostic of myocardial infarction, serial curves usually reveal the true situation. The progressive electrocardiographic changes following myocardial infarction, as seen in serial curves recorded at properly timed intervals, are sufficiently characteristic that there are few instances in which coronary

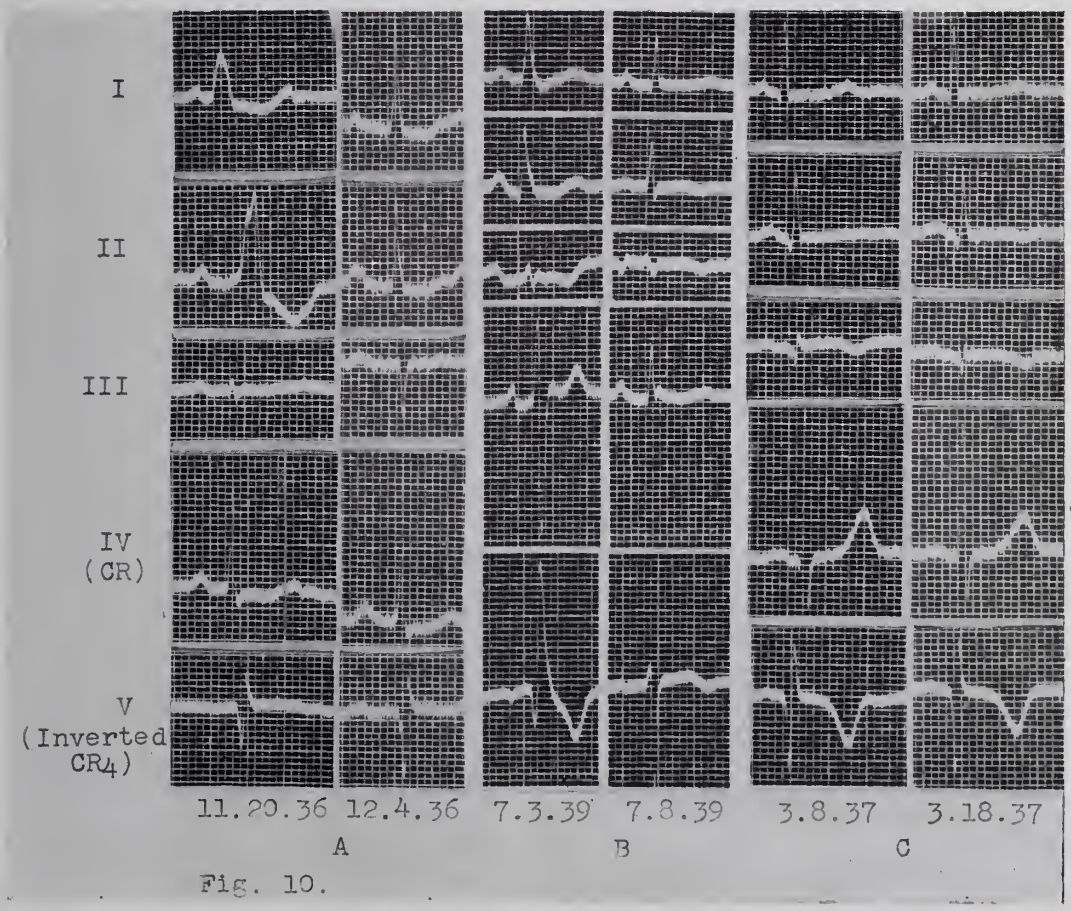

Fig. 10. Atypical changes of infarction as shown by subsequent curves.

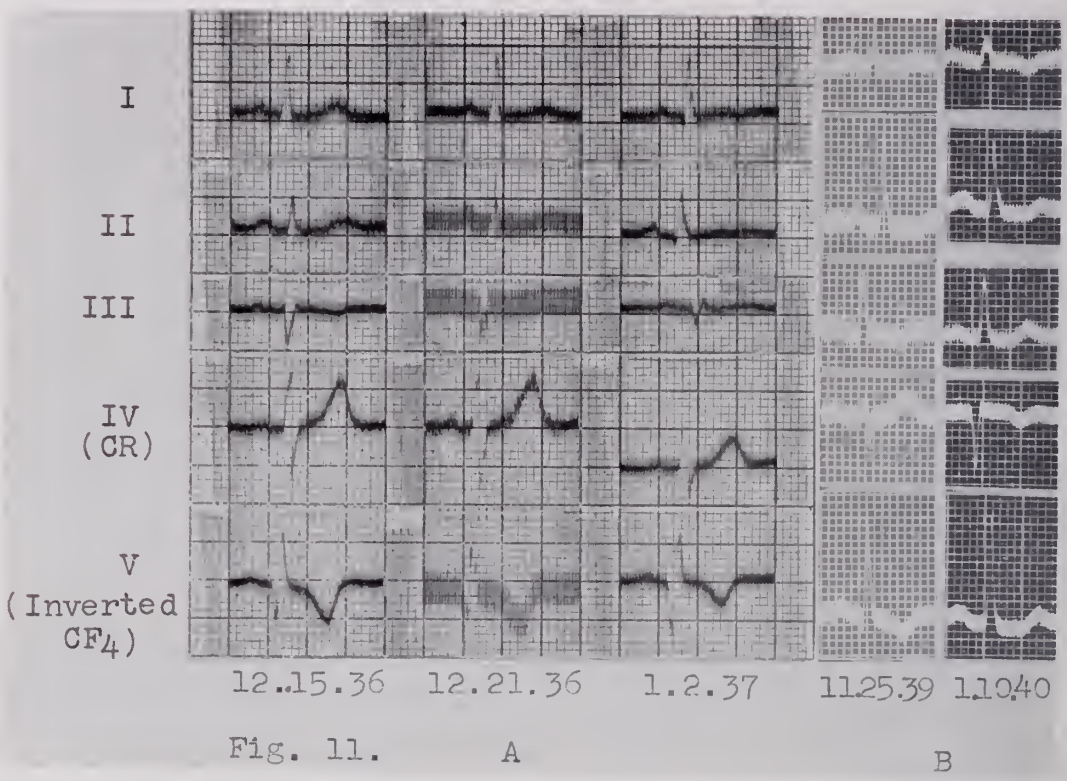

Fig. 11. Additional instances where serial curves were essential for diagnosis. Note R_4 and Q_3 in A.

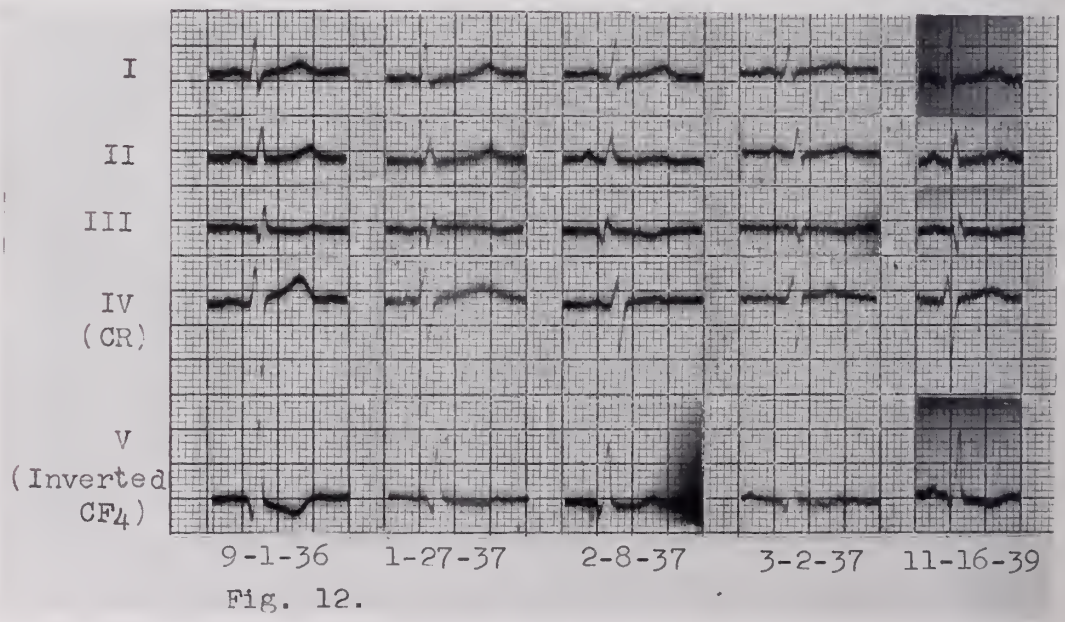

Fig. 12. Serial curves of an atypical posterior basal infarction.

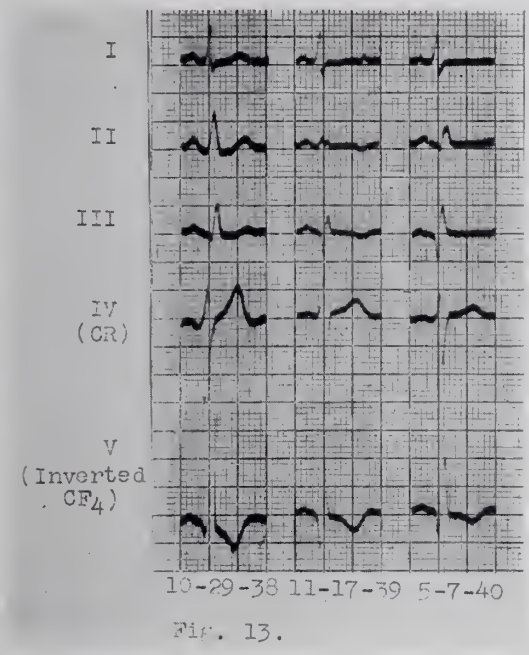

Fig. 13. Diagnosis of occlusion possible only after second record.

occlusion cannot be diagnosed. "No other condition has produced the complete typical picture of acute cardiac infarction."[32]

Again, there is no better way to follow the progress of the patient who has sustained an acute coronary occlusion than to observe the course of the typical graphic changes that result from the process of infarct organization. Symptoms and findings are frequently undependable and at times misleading. Properly timed serial records are often of great assistance.

Summary

The more widespread use of serial curves in the study of patients with minor complaints of coronary disease or of mild or atypical pain equivalents will bring to light a surprising number in which an occlusion of a lesser coronary branch, and occasionally even of one of the larger coronary vessels, has occurred. Minor attacks cannot be too carefully and rigidly studied. With the proper use of electrocardiography in diagnosis there will be an increase in the reported low incidence of painless[47] as well as atypical coronary occlusions. Likewise, there will be a decrease in the reported

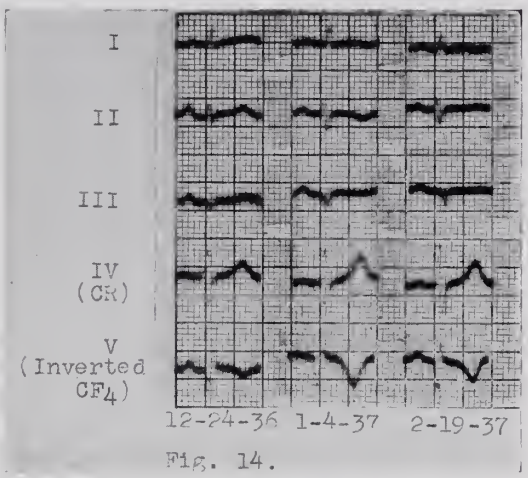

Fig. 14. Serial curves of a posterior infarction.

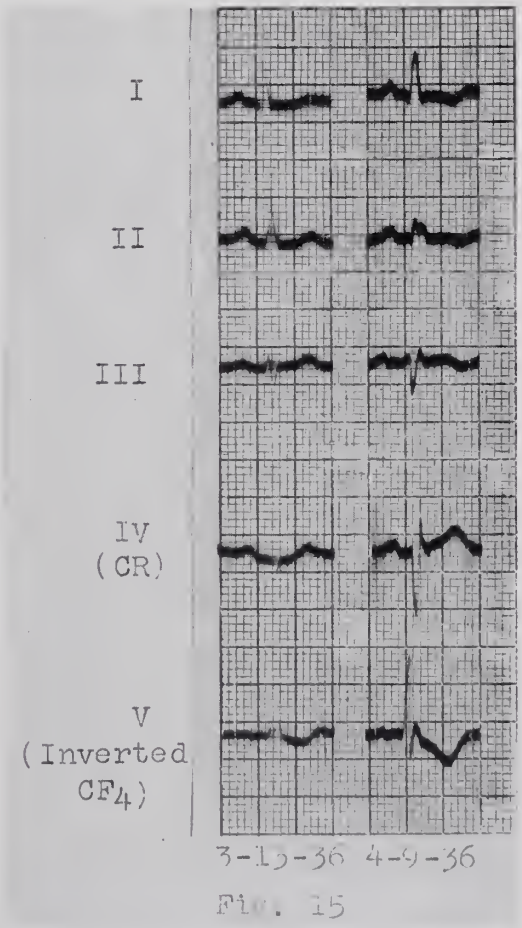

Fig. 15. Diagnosis of infarction established by serial curves. Note that R_4 and Q_3, present in the initial curve, are absent in the later record.

occurrence of the "prodromal pain"[48] of coronary occlusion.

The most valuable recent advance from a clinical point of view has been the more widespread appreciation of the importance of serial curves.[6–9, 49]

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Mental Deficiency as a Problem in General Practice

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MOST physicians in general practice are called on occasionally to deal with the problem of mental deficiency either in private patients or in patients referred by the courts. The physician may be asked for advice by the parents and relatives of some feebleminded child or by those interested in a child seemingly unable to compete with his schoolmates upon equal terms. Cases involving feeblemindedness may also be brought to the physician through legal channels, for a provision of Wisconsin law directs that in certain instances the courts shall request the physician to determine whether a specific individual is a fit subject for commitment to an institution for the care and training of mentally defective patients.

Commitment

It has never been considered a mark of distinction for an individual to have been committed to an institution for the feebleminded. These institutions have been established for the care and training of patients who, because of their inadequacy, require a particular kind of care and supervision, and the commitment of an individual to such an institution without adequate diagnosis and careful consideration for his future welfare, as well as concern for the effect upon his family, may result in grave injustice. Care in making commitments is necessary for the sake of the institution as well, for, although these establishments perform an invaluable social service, they can be highly effective only if they are permitted to devote their efforts to patients urgently in need of their services and for whom no other suitable provisions can be made.

The Wisconsin statute placing legal responsibility upon the physician for the recommendation of commitments presupposes that all members of the medical profession have a thorough knowledge of the nature of mental deficiency and the means of its diagnosis and, in addition, an understanding of the work and objectives of the institutions to which the patient may be transferred; but the specialized character of the problem makes it likely that the physician in general practice will be able to act in many of these cases only with certain misgivings.

Feeblemindedness is not simply a medical problem. It must be considered as a condition rather than as a disease susceptible to remedial therapy, and a full understanding of the social and psychologic implications of mental defect is fundamental in devising appropriate treatment. The study of mental deficiency usually has been regarded as a stepchild of neuropsychiatry and, as a consequence, it has not received much stress in our medical schools. The highly specialized literature on feeblemindedness ordinarily is not readily available to the practicing phy-

sician who in any event is already overburdened with more reading material than his time allows. The general medical practitioner is, therefore, forced to bear profound moral and legal responsibility in solving this complicated social problem, a duty for the performance of which his medical training may have given him only limited preparation.

Fundamental Concepts

It is for the purpose of aiding physicians in their difficult task with this special group of patients that the following summary of important facts about mental deficiency is presented. We shall review briefly certain fundamental concepts concerning the nature of mental deficiency and compare various methods of diagnosis. Because the problem of mental defect is primarily a problem of human relationships, we shall then consider the factors upon which ultimate treatment and disposal of these patients must depend.

Mental deficiency is not a disease but a condition of arrested intellectual growth in early years. If the intellectual capacity of an individual does not develop at the rate and to the extent of that usually found in the healthy individual, we speak of him as feebleminded. This inadequate mental development is not due to a sudden and complete arrest, but is manifested, rather, as a subnormal *rate* of development. Furthermore, retardation is not uniform; obstructed in one direction, development may have progressed in others. Although it is possible for certain degrees of mental retardation to remain undiagnosed until relatively late in an individual's development, the feeblemindedness, by definition, exists from, or near, birth. Mental deficiency does *not* suddenly develop at the age of fourteen or twenty!

The mental defective differs from the insane in that the former never possessed a normal endowment, whereas the insane or deteriorated individual has lost some of his original ability. The feebleminded may be likened to a poor man who has never been rich, while the insane individual resembles a rich man who for some reason has become poor.

Two major types of mental deficiency may be distinguished from the standpoint of etiology: namely, the endogenous and the exogenous. In the former, the endogenous group, we are dealing primarily with a hereditary factor. The individual is born feebleminded because he has inherited his psychobiologic insufficiency from his ancestors. Instances of apparently clear familial mental deficiency account for roughly one third of all institutional cases.

In exogenous mental deficiency we include individuals who are born with suitable capacities for development but in whom some injurious factor (encephalitis, head injury, etc.) has prevented normal development. This group includes those pathologic alterations of development represented by clinical varieties of mental deficiency. Such cases account for approximately a second third of the institutionalized mental defectives.

The last third consists of all cases of mixed or obscure etiology. It includes the so-called subcultural individuals and those persons for whom psychologic and emotional factors have interfered to a marked degree with mental development. These persons cannot be regarded as presenting typical feeblemindedness from the standpoint of etiology, but in all other respects they are truly mentally defective.

With respect to severity of defect and capacity for learning, three main types of handicapped children can be described (aside from clinical classifications). The most severely handicapped of the mentally defective are commonly referred to as of the *idiot* grade. This class includes those children who are insensible to danger, who have little or no use of language, and who are incapable of attending to their physical needs. Despite the fact that they may attain normal physical maturity, the upper limit of their mental development will be less than that of a 3 year old child. They are not educable under public school conditions and even as adults will require constant personal care.

Feebleminded, *imbecile* grade, constitutes the next highest type in this classification.

These children may be considered as capable of attending to their physical needs and, with special training, they can learn to perform many simple and useful occupational tasks. At physical maturity they will continue to require more or less constant supervision since they are unable to make independent social and economic adjustments except under unusually favorable conditions. Their mental development at maturity will remain below the 8 year level and they seldom progress beyond the second grade in academic work, even under special methods of instruction. Imbeciles are generally more successfully trained in separate institutions than in the public schools, except where special provisions are made for the mentally retarded. Although there is ordinarily little difficulty in recognizing them by standard test procedures several years earlier, members of this group may escape detection before school age. Their lack of academic aptitude usually becomes evident the first year in school.

The *moron* grade of the feebleminded includes children above the imbecile level who, because of their intellectual handicap, are unable to cope with even the dull and inferior normal groups. They may learn to perform unskilled occupational and industrial tasks with a certain degree of facility, but they are incapable of earning an independent living except under favorable conditions and with supervision. A well trained moron may acquire advantageous social habits enabling him to respond favorably in an established routine, but he is generally incapable of adjusting to changing social and industrial conditions without outside help, either from his family or some social agency. At physical maturity the mentality of the moron corresponds approximately to the mentality of an 8 to 12 year old child (It must not be supposed, however, that his social and emotional reactions are identical with those of the normal 8 year old). Children of moron grade may be able to learn to read and write, but they usually profit little from ordinary academic instruction beyond the fifth grade.

Diagnosis

A diagnosis of mental defect may be made from any one of several points of view. In the *common diagnosis* the examiner merely formulates an opinion that the patient is not very bright. Even a high-grade institutionalized mental defective is able to diagnose thus vaguely the condition of a patient of lower grade. This method of casual observation may be suitable for gross abnormalities and severe deficiencies in which even a rough comparison with the so-called normal individual shows the patient's insufficiencies, but it is not appropriate for the majority of cases of mental defect.

A *medical diagnosis* alone is suitable only for gross organic defects and for a variety of sharply defined clinical cases involving any one of the several organic deficiencies. Although these cases are often clear-cut and interesting, they nevertheless are relatively rare even in institutional populations. Whenever the high-grade borderline case is under consideration, wherever psychologic and social elements enter into the case, a medical diagnosis alone is insufficient.

A diagnosis of mental defect solely on an *educational* basis is of very doubtful value since it generally takes into consideration only achievement, or rather, lack of academic achievement, without regard for cause. Often no attempt is made to evaluate the child's developmental background, his training or lack of training, or any emotional factors that may be involved. Many cases of previously undiagnosed mental deficiency become evident through the individual's lack of academic aptitude, but a broader analysis of the child's abilities is necessary for a comprehensive diagnosis.

In the *psychologic diagnosis* standardized methods of evaluating an individual's capacity in comparison with the abilities of other persons of like background and chronologic age are employed. Standardized interviews have been developed which, in the hands of a trained and competent examiner, one qualified not only to administer and score these examinations but also to interpret the total test data, result in a more reliable evaluation of mental capacity than any

other single diagnostic procedure yet developed. Of the great variety of mental examinations available, only the individually administered test can be considered as having diagnostic value for the determination of mental defect.

Examinations

Perhaps the most widely recognized of these mental examinations is the Stanford Revision of the Binet Scale, a test consisting of a series of standardized problem situations designed to sample a large variety of mental abilities. This examination is an individually administered test requiring special equipment and forms, and yields reliable results only when given by an expert in Binet measurement.

Since this examination is based upon mental test data secured from thousands of individuals over a period of more than twenty-five years, the norms established accurately reflect the expected mental development of average children. Hence the results of an examinee's performance on this test can be interpreted in terms of mental age; that is, his test behavior can be compared with the expected performance of an average child of a specific age. For example, a normal 6 year old child can be expected to attain a mental age of 6 years; that is, he will be able to function on the 6 year level. A 6 year old individual who is able to do all the tests rated as 6 years and, in addition, some of the tests of the 7 year level shows a better than average performance. In like manner, an individual who is not able to pass the tests ordinarily performed by his particular age group is rated as having a mental age below his chronologic age and therefore he is spoken of as being mentally retarded. The concept of mental ages thus enables us to compare the test performances of individuals of like chronologic ages.

If we wish to compare the test performances of individuals of different chronologic ages, the test scores can be expressed in terms of a quotient, the well-known and much-abused "I.Q.," or intelligence quotient. This term expresses by means of a proportion the relationship between an individual's mental age and his chronologic age, or mathematically expressed, mental age divided by chronologic age. An individual aged 6 years, 6 months who receives a mental age rating of 6 years, 6 months has an I.Q. of 100 according to this notation (technically 1.00, the decimal point being dropped as a matter of convenience). On the other hand, if this 6 year, 6 month old child scores 6 years, 10 months mental age on his examination, his intelligence quotient is greater than 100 or above average. Dividing 6 years, 10 months mental age by 6 years, 6 months chronologic age, we find an intelligence quotient of 105.

If, however, our 6½ year old child is not able to perform any of the tests above the level ordinarily expected from a 4 year old child and, when his performance is scored, a mental age of 3 years, 8 months is found, we know that his mental level is less than average, that his I.Q. is less than 100. Dividing 3 years, 8 months (his mental age) by 6 years, 6 months (his chronologic age), we find his intelligence quotient to be 56.

If administered under suitable conditions with due allowance being made for physical, sensory, and other handicaps, the Binet and the Binet type of mental tests produce reliable results. The intellectual development of the mentally retarded does not cease abruptly at any specific point, but merely proceeds at a reduced rate as compared with that of more normal individuals. In the mental defective as well as in the normal person, mental age increases with life age, but at a slower rate. An individual's I.Q., however, can be expected to remain relatively constant throughout his life, thereby furnishing a convenient, if perhaps oversimplified, index to his probable future performance.

Although any one of the diagnostic procedures described above, if performed with skill and consideration for special circumstances, yields valuable information in studying cases of suspected mental deficiency, no single one of them by itself can be regarded as adequate for a final diagnosis and guide to treatment. The mentally deficient individual does not function in a

vacuum, nor does he react to his environment with only one aspect of his nature. Like all other individuals, he is a unit in the social organism and responds to his surroundings and daily routine with his entire personality. Any thoughtful diagnosis of mental deficiency therefore must include a consideration of the complete personality of the patient, his past history, and his possible future development. This kind of diagnosis necessitates an analysis of the kind of defect involved, the degree of insufficiency observed, and, if commitment to an institution is contemplated, an understanding of the kind of care and training which the available institutions are capable of giving this particular individual. No diagnosis of mental defect can be considered worthy of the name unless it takes into consideration the individual's entire nature, his complete personal and family history, his emotional and habit training and reactions, his physical and his mental constitution, and his reactions to himself and to the world.

A Humanitarian Problem

No matter how careful and complete a diagnosis may be made, however, all of our diagnostic methods remain merely means to determine the kind of care most suitable and the degree of supervision most beneficial for the individual and for society. The primary cause for our concern about the mental defective is his inherent incapacity for managing himself and his affairs with ordinary prudence and his inability to maintain himself independently above the marginal level of subsistence in competition with his more normal brothers. It is most important to realize that, despite the varied aspects which this problem presents in special fields, mental defect is, and must always remain, primarily a humanitarian problem existing in a social world. The legal, medical, educational, and psychologic approaches are only means to an end, and that end is the care and the training of individuals who for some reason are unable to take care of themselves without outside help or supervision.

The mentally deficient individual is characterized by, first, his lack of original endowment, and secondly, by his lack of ability to use in a socially constructive manner the meager endowment he does possess. By the very nature of his deficiency little or nothing can be done to increase the feebleminded individual's intellectual capacity; he has always been mentally retarded and he will always remain so. In overcoming the second handicap, however, much can be accomplished; it is possible to train the individual in social and emotional habits so as to enable him to use to the best possible advantage all the ability he does possess. Since even the low-grade mental defective must take his place in a social order of some kind, this form of training is highly important. It is in social relationships, too, that the high-grade defective frequently becomes involved in difficulties. It is in the social and economic fields that the mental defective's inability to compete on equal terms with his normal and brighter brother is clearly revealed, and here proper training can be most effective.

Since the individual functions in an environment, the inter-reaction of the two must be considered and, if possible, an effort should be made to adjust the environment to the patient's needs. It is as important to examine the social setting as to examine the individual himself. Whenever commitment of a patient to an institution for the mentally defective is contemplated, it is actually the environment that has been found unsuitable and which is to be changed. It must be remembered that only a small percentage of the total number of mentally deficient individuals either can be or should be institutionalized. However, if satisfactory conditions cannot be arranged in the home community, we may feel that the environment and training within an institution are better suited to a particular patient's special needs than are the surroundings in which he now lives.

Mental deficiency, then, is not a simple problem; patients presenting evidence of mental retardation must not be regarded as requiring merely certification of feeblemindedness followed inevitably by institutionalization. Whether one regards feeblemindedness as a legal, a medical, or a social problem, it remains a human relationship in

which we are trying to direct all of our efforts to serve best both society and the patient. If we fully appreciate the grave moral and legal responsibility which rests upon us in making our diagnosis, we will not limit our technic to any single approach. It is not enough to consider merely one aspect of the patient's total nature; we must also study the home and the entire physical and social environment in which the patient is living.

Since appropriate and adequate diagnostic procedures, however necessary of themselves, lose most of their value unless followed by proper subsequent treatment, all available means of training and caring for the mentally defective patient should be examined, and, before recommending institutionalization, we must evaluate with care the institutional environment into which we propose to place him. Only on the basis of this comprehensive analysis, after a consideration of the home and community background, the patient's entire nature, and the suitability of the care and training which the institution is able to provide, can we attain an intelligent solution to this very complex social problem.

Constitutional Asthenia*

By C. W. OSGOOD, M. D.
Wauwatosa

IN THE course of private sanitarium practice I have been impressed by a small group of patients difficult to classify but having in common prolonged and persistent fatigue and lack of energy. Insomnia, vague psychosomatic distress, and variable depression have also been noted, but *constant* and *outstanding* have been complaints of fatigue and resulting inadequacy.

I have reviewed the records of 5 such patients who were at the Milwaukee Sanitarium for from one and a half to over six years. All were cooperative and were cared for in an open unit. Four were women and one a man. Their ages on admission ranged from 29 to 58 years and all had been married except one woman. According to the histories, none of them had ever been very energetic or aggressive before admission nor has any become so since leaving. One continues to spend part of each year at the sanitarium and another left only recently.

A composite case history would read about as follows:

This woman was never very robust as a child. She comes of a family of which several members show energy deficiencies or nervous instability. She did creditable work at school but made no important occupational adjustment. Perhaps she is married and has a child, but she has found the responsibilities of life increasingly difficult, and after a few years has finally taken refuge in a sanitarium.

Physical examination showed undernutrition and evidences of instability of the sympathetic nervous system. Laboratory tests showed slight anemia or blood counts at the lower limit of normal, blood sugar tending to be low but with a high glucose tolerance curve, and basal metabolic rate normal or at the lower limits of normal.

The patient remained in bed for the first week or two, then began to walk a little and gradually to mingle with the other patients. She attempted mild exercise but felt completely exhausted and returned to bed with a discouraged feeling that she had attempted more than she should. Her course was marked by repeated slight gains in energy with subsequent relapses and by corresponding fluctuations in weight. Eventually, because of financial pressure or urging of relatives, she reluctantly and with misgivings left the sanitarium. In a week, perhaps, she was back more miserable than before, but she again made a gradual gain until eventually she was discharged. Reports were received from time to time that she managed

* Read before the Milwaukee Neuro-psychiatric Society, November 27, 1941.

to get along but that she still could not attempt to do much.

All five of our patients had regular recurring attacks of "utter prostration" in which they might go to bed, close their rooms, and darken the windows. These followed "overdoing" and the patients spoke of "setbacks." These setbacks were apparently *not* related to emotional experiences but followed some increase in activity.

All the patients were self-centered and showed far less than normal concern regarding their responsibilities to family or expense involved in their care. Their general range of interests was greatly narrowed, although well sustained in some few fields. For example, one showed interest in literature and developed the hobby of banding birds; another assembled and operated a radio broadcasting set; and a third showed interest in translating foreign languages and in social problems. All shrank from undertaking any responsibility and were content to go on indefinitely at the sanitarium.

In spite of fatigue, these patients were unable to sleep during the day, and at night slept restlessly with the aid of hypnotics. Two were troubled by constant dreaming. All showed more or less depression, usually not severe, although one attempted suicide before coming to the sanitarium and another had definite suicidal thoughts during a later phase of his illness while at the sanitarium. Complaints of headache, dizziness and diarrhea were common. None of the patients, however, had obsessions, compulsions, or phobias aside from some hypochondriacal fears.

Etiology

In considering the etiology of these fatigue states, it is to be noted that none of the patients described here was ever very energetic. This suggests a constitutional defect based either on heredity or early environmental influences. Instability among the relatives was a frequent finding; for example, one patient was said to have an unstable father. Another had a mother who was unhappy and nervous, a father who was shut-in and asocial, and an aunt and cousin who were much like herself. A third patient had a sister who was a chronic invalid and a daughter who was irresponsible. Another had a domineering alcoholic father and a neurotic mother besides uncles who were described as neurotic or alcoholic. The parents of the fifth were "nervous."

Situations productive of emotional disturbance were present but seem insufficient in themselves to account for the symptoms. For example, one patient was unhappy at preparatory school because of failure to make a certain sorority and later left frustrated in her desire for a career because she was expected to remain at home with her parents. Another had married a man younger than herself after a long courtship and against parental advice and then had had a baby four months before admission to the sanitarium. Another had first shown symptoms following an accident resulting in some facial scarring and had later broken down after moving with her husband and children from her home city to that in which her husband's family lived. In another instance, there had been financial losses prior to the first admission and death of relatives with whom the patient made his home before one of his later admissions.

One patient showed hyperostosis frontalis interna on roentgenologic examination of the skull, and fasting blood sugar readings averaging about 74 mg. per 100 cc., with one reading as low as 42 mg.

Originally we classified these patients either as depressive or psychoneurotic, but we did not feel that they were typical. The syndrome approximates that variously called neurasthenia, irritable weakness syndrome, or chronic nervous exhaustion. The concept of neurasthenia is vague and variable as discussed by various writers. Rosanoff[1] doubts whether such a diagnosis is really justified, and says, "Today the diagnosis of neurasthenia is made not nearly so often (as in Beard's time, the latter part of the last century). Perhaps it should never be made, unless it be only with the explicit understanding that it refers to cases not sufficiently cleared to make possible their more definite classification." He thinks such cases may be instances of overlooked organic disease such as early cancer or tuberculosis, or that they

may be early psychoses. Macy and Allen[2] of The Mayo Clinic refute this point of view. On re-examination of 235 patients so diagnosed, on an average of six and a half years after the original examination, they found that the diagnosis was confirmed in about 94 per cent.

Several authors have described fatigue states and have variously classified them. Benon[3] describes asthenia as episodic, chronic, periodic, and constitutional. Gillespie[4] speaks of constitutional cases, neurasthenia or irritable weakness, and fatigue due to organic disease. Deschamps[5] divides asthenias into those of production and those of distribution. Bortz and Piersol[6] extensively reviewed the whole subject of asthenia.

When constitutional and organic types of asthenia are excluded most authors stress the etiologic importance of emotional disturbance in the remaining "neurasthenics." Other "dysthenizing agents" are described, however, as pain, trauma with associated loss of consciousness, infections such as influenza and typhoid, and surgical operations.

In the selection of the cases to be included in this report we eliminated all those patients in whom any of the above factors seemed important, as well as patients in whom fatigue was an element in a primary depression or an equivalent for a depressive attack.

These 5 cases are presented as examples of that rare *constitutional* asthenia mentioned by several authors but described only casually. While it is recognized that constitution probably plays a role in all disease states and that there can be no sharp division between conditions due to constitution and those due to environmental factors, the cases here presented appear to be overwhelmingly constitutional.

As Störmer[7] says in his discussion of constitutional asthenia and its management, there is some doubt as to a real therapeutic effect on a constitutional predisposition. Nevertheless, he attempts to influence disturbances of metabolism and of endocrine balance which he believes to be present. Therapeutic measures recommended by various authors in constitutional as well as other varieties of asthenia include high fat diet or frequent small feedings to counteract hypoglycemia, injection of calcium gluconate to correct low blood calcium, phosphates to improve the working power of the muscles, endocrine products, especially thyroid, estrone, and adrenal cortex, various drugs acting on the sympathetic nervous system, and general measures such as diet, proper exercise, and physical therapy.

Many of these therapeutic aids have been tried in these cases but without conclusive results. One patient on a return admission, many years after the first hospitalization, was given a few metrazol shocks but without benefit. A second patient received two courses of metrazol, dauerschlaf, electroshock, and finally a full course of insulin shock over a period of two years without pronounced benefit, except for clearing of acute depressive symptoms following the metrazol.

My experience inclines me to believe with Bortz and Piersol[6] that, "In the case of constitutional asthenia, the best advice would seem to be for the individuals to stop trying to develop themselves to normal physical and nervous capacity, but to determine what their maximum abilities are and keep slightly under that limit."

The whole subject of energy is an interesting one. As one looks at his fellows he can observe wide variations in dynamic drive. In cyclothymic persons he can see great swings in energy with the swings in mood, and in the schizophrenic patient he is apt to see a progressive, permanent decrease in energy going along with loss of interest. Moreover, decline in energy with advancing years is physiologic. The patients of whom I am particularly speaking appear to have an inherent lack of stamina, which does not actually increase in degree but becomes progressively apparent as the demands of life increase.

Jastrow[8] says, "The problem for each of us, with close regard to the nature of his power plant, is to find the best equilibrium of energizing and rest; this is more than the maximum achievement, or the *most* one can

do, in that it is the optimum, the *best* that one can do." This general advice applies particularly to the constitutional asthenic.

Summary

I have described a small homogeneous group of patients from unstable families, lacking energy from an early age, unable to meet the ordinary demands of life after early middle age, and suffering from feelings of inadequacy. It is my impression that the energy deficit is constitutional and primary with feelings of depression and inadequacy concomitant but secondary. Patients have been encouraged to accept their limitations and live within them, first within the environment of the sanitarium but finally outside of the institution. Three of the 5 patients eventually succeeded in making limited adjustments on the outside; 1 patient only recently left the sanitarium after more than a year and a half; and the other still returns periodically.

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The Role of Examiners and Consultants in Compensation Cases

AT A recent meeting of the Conference Committee on Open Panels, a case which involved both the question of a medical examiner for an insurance company and a consultant was presented for adjudication by the conference committee. A recommendation was made by the committee that through the pages of *The Wisconsin Medical Journal* an effort be made to clarify the role both of the examiner and the consultant.

The Workmen's Compensation Act provides that the employer or the insurance carrier may cause an examination to be made of the injured employe by an examiner of their selection. The examiner is authorized to inquire into fact and condition, and his responsibility is to report his findings to the employer or the insurance carrier. As an examiner, he is not called upon to recommend treatment, nor to make any comment whatsoever to the injured employe concerning the treatment to be followed.

Under the terms of the Open Panel Agreement, if either the physician or the insurance company desires a consultant, as distinguished from an examiner, such consultant must be mutually agreed upon by the attending physician and the carrier or employer involved. Consultation embraces an examination of the injured employe and conference with the attending physician as to the course of treatment which he should follow. Consultation in compensation cases does not, unless it is so requested by the attending physician, imply treatment of the injured employe.

Physicians engaged by employers or insurance carriers as examiners should refrain from commenting upon treatment, should refrain from recommending treatment to the injured employe, and should confine their efforts solely to reporting facts either to the carrier or the employer.

Professional considerations governing consultation should be observed in these instances in precisely the same manner as they are in private practice. The provisions of the Open Panel Agreement covering the question of consultation follow:

> When consultation is desirable, I will obtain consent of the insurance company, when possible, *prior* to calling in consultation, and whether consultation is requested by me, the patient, or the insurance company, every effort will be made to secure a consultant mutually acceptable.

Comments on Treatment

Editor—A. J. QUICK, M. D., Marquette University, Milwaukee

Fever and the Antipyretic Drugs

The antipyretics are among the most effective acting drugs; yet, paradoxically, they are rarely employed for their prompt fever-reducing activity but rather for their analgesic and other pharmacologic properties. The most important groups of drugs which have marked antipyretic action are: (1) the salicylates; (2) the aniline derivatives, acetophenetidin and acetanilid; (3) the pyrazolone derivatives, antipyrine and aminopyrine; (4) the cinchoninic acids, cinchophen and neocinchophen; and (5) quinine and related compounds.

Actually quinine is a relatively poor nonspecific antipyretic, but is very effective in malaria since in that disease it acts specifically on the cause of the disease, and the fall in temperature is secondary to this action. Likewise, the reduction of fever in pneumonia and other infectious diseases following treatment with sulfanilamide and related compounds is secondary to their chemotherapeutic effect. The true antipyretic drug acts directly on the temperature center of the brain and is effective only if the temperature is above normal. The reduction of the fever is accomplished by an increased rate of perspiration and by cutaneous vasodilatation.

It is a curious fact that the antipyretic drugs are also the best analgesic agents (next to the opium derivatives). As a result they are widely employed and in general are relatively nontoxic. Yet in this group are some of the most insidiously dangerous drugs such as aminopyrine and cinchophen. The first is responsible for the majority of cases of agranulocytosis while the second is a frequent cause of acute yellow atrophy of the liver. Fortunately the aniline derivatives and the salicylates are safe drugs when employed properly.

Under what conditions are antipyretic drugs employed? To answer this question it is necessary to point out that moderate fever *per se* does no harm and may perhaps actually serve as a defense against infection. Therefore reduction of fever is desirable only if it is excessively high and is endangering the patient, or if it will contribute to his comfort. This can usually be accomplished without drugs. The sponge bath is not only effective in lowering a dangerously high temperature, but it also does much to ease the restlessness and distress of the patient.

Nevertheless, it is unwise to speak disparagingly of the antipyretic drugs, for they do have their place in therapy. Since these agents combine antipyresis with analgesia, they often can contribute much to benefit the patient. There can be no doubt that the effect a few grains of aspirin may have in easing a child tossing feverishly about in his crib cannot help but be beneficial. The therapeutic value of the antipyretic and analgesic action of salicylates in rheumatic fever is, in the opinion of the writer, underestimated.

In summary, it can be stated that antipyretic drugs are now rarely administered primarily to reduce fever but are given for the comfort of the patient who requires an analgesic. The fever itself can be best controlled by sponge baths and other forms of hydrotherapy. It must also be remembered that fever brings about a marked loss of fluid and undoubtedly an abnormal destruction of vital metabolic materials, particularly the vitamins. Therefore attempts should be made to restore the water balance by increasing the fluid intake, and it seems desirable that the patient be given extra vitamins, especially of the water-soluble type. A. J. Q.

The Nation at War

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Wartime Activities to Be Featured at Meeting

SINCE December, *The Journal* has carried a section on "The Nation at War" in each of its issues, that in it the members of the Society might find information of particular value relating to the medical profession and its wartime activities. Metaphorically, at least, this section of *The Journal* will be transplanted in detail to the annual meeting. There, will be found a special booth, staffed by Army officers prepared to answer the physicians' questions relative to service in that branch of our armed forces. There will be a similar booth maintained by the Navy for the same purpose. The Procurement and Assignment Service will be represented by Dr. R. E. Fitzgerald at the roundtable luncheons each noon, before the general session on Tuesday and in a booth in the Main Arena where he may be consulted by physicians at various intervals during each day of the annual meeting.

Other announcements have been sent you outlining the program of the Society as it relates to the physician and the war in detail. Valuable information will be available and the members of the Society are urged to make use of these opportunities.

Occupational Deferment For Medical Students

SELECTIVE Service registrants enrolled in professional or scientific schools may be considered for occupational deferment, according to recent instructions furnished local draft and appeal boards by Lieutenant Colonel John F. Mullen, acting state director of Selective Service.

This bulletin was issued to clarify information sent to state directors pertaining to the cases of registrants enrolled in professional or scientific schools (admission to which is customarily not granted until a student has completed at least two academic years of work, and often four academic years of work), and particularly to the cases of premedical and medical students, and of those similarly situated.

When the premedical student has been accepted for enrollment in a medical college, he may be considered for occupational deferment as a medical student, provided classroom work will soon commence. After the academic work in the medical college has actually started, the registrant may be considered for occupational deferment in each of the four academic years of medical college work.

Although no specific direction on premedical students has been issued, local boards have been advised that a student may not be considered for deferment until he has completed, or approximately completed, two academic years of college work. If he continues work at the undergraduate level and is in the junior or senior years of premedicine, he may be considered for occupational deferment.

Third and fourth year pharmaceutical students will also be given careful consideration for occupational deferment, provided they are in good standing in their respective college courses.

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Advertising Representative: Cooperative Medical Advertising Bureau, 535 North Dearborn St., Chicago, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, Madison

Volume 41 | SEPTEMBER, 1942 | Number 9

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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« « « EDITORIAL » » »

Another Wartime Activity

IT BECAME apparent, as stated in this column in July, that activities of the State Medical Society would necessarily develop in the field of securing replacements where acute needs existed either to permit a physician to be released for military service or to replace one already entered.

In the report of the Council in this issue and in the August issue of *The Journal* reference was made to the Subcommittee on Replacements of the Committee on War Participation. This subcommittee, under the chairmanship of Dr. R. W. Blumenthal, is now actively functioning. Questionnaires are being sent those physicians who by their enrollment with the Procurement and Assignment Service as a division of the War Manpower Commission have signified their willingness to serve their country in ways other than with the armed forces, if the latter should be impossible.

Constant contacts will be developed with representatives of the community, industry and state agencies who find need for such services, and the committee is undertaking a monumental task in serving the health needs of the people during this period. There is a niche in the national picture for all physicians be it in the armed service, in industry, in the community or in the civil service of government. The Subcommittee on Replacements invites inquiries from members of the Society who are interested in availing themselves of this opportunity to serve in the wartime activities.

. . . . THE PRESIDENT'S PAGE . . . .

Recapitulation

THERE are many thoughts which pass through the mind of the man who is about to "sing his swan song" as president of the State Medical Society of Wisconsin.

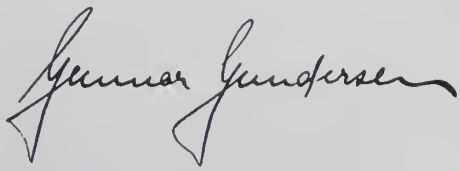
It has been a year of turmoil due to internal as well as external causes.

Internally, the problems which came to focus as a result of the loss of our secretary, and the necessity of replacing George with a new leader were immediately pressing. I am confident the choice of Charles H. Crownhart to succeed his brother will prove to be a happy one. Those of us who have had the good fortune to work closely with him and thus get to know him more intimately are constantly impressed with his broad approach to problems involving policy, his loyalty to the memory of his predecessor, and his rapidly developing grasp and control of office detail and routine. The eagerness, enthusiasm and conscientiousness with which Charlie has taken hold have made the burden of your officers easy as well as pleasant. Charlie has "grown" on me as I am sure he will on all who get to know him better as time goes on. I wish for him and his office staff every success.

Externally, the problems became multiplied many fold as a result of the active participation of our country in the World War. The entire energies of the office personnel might well have been spent on the requirements of the Society as they relate to the war effort. In a measure we were fortunate that 1942 was not a legislative year. Had this burden also been ours this year, a doubling of administrative help, as well as clerical help, would have been incumbent.

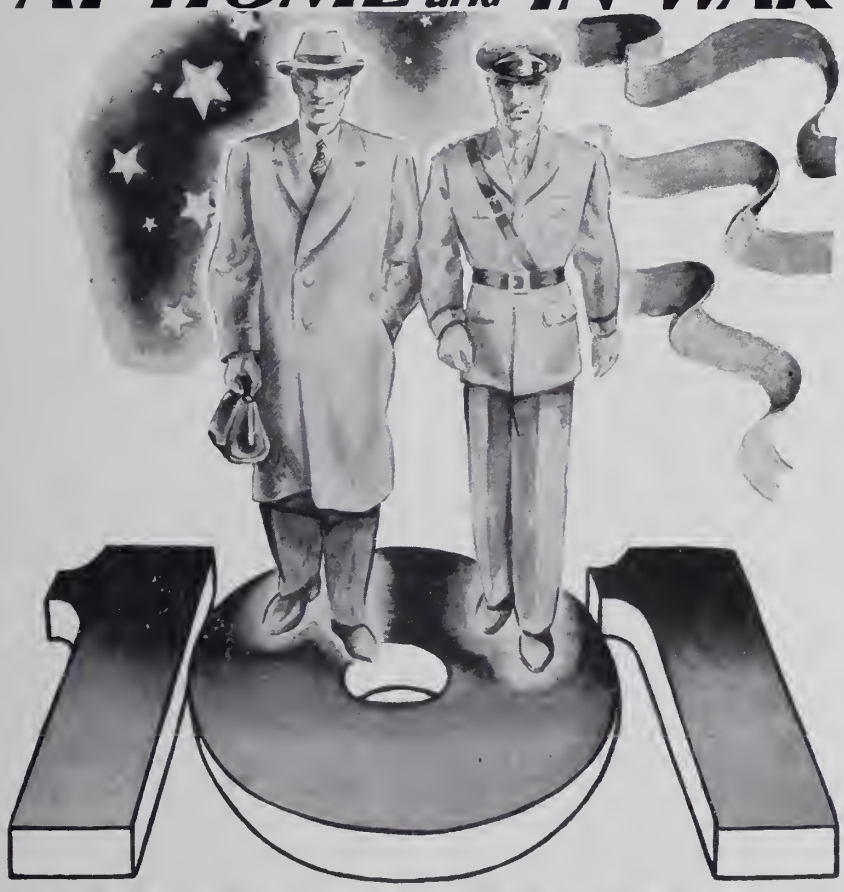
The two problems mentioned above stand out as illustrative of only a few of the innumerable ones which arose to keep your president out of mischief.

The problems associated with the biennially recurring legislative session fall upon the shoulders of the man who takes office this month. For Frank E. Butler, of Menomonie, I bespeak the same sympathetic co-operation which has been accorded me. In his steady and capable hands and under his seasoned guidance, the medical ship of state should have a year of prosperity and increasing usefulness to its members.



1941
Elastoplast
PREVENTION OF
OCCUPATIONAL DISEASES

MEDICINE AT HOME and IN WAR



anniversary PROGRAM

War Program at Annual Meeting to Have Serious Attention of Members

THE serious attention of upwards of 1,200 members of the State Medical Society will be directed to the scientific program which will stress the participation of physicians in the active war effort and Emergency Medical Service under the Office of Civilian Defense. The preparation of this program was particularly difficult in order that proper emphasis might be given both to the recent advances in the treatment of wartime conditions and to civilian diseases and injuries. Dr. Erwin Schmidt, member of the Council on Scientific Work who has been charged with the development of the scientific program has succeeded admirably in maintaining a proper balance between these two current phases of medicine.

War Medicine

Experiences of English physicians have indicated that civilian and military injuries of modern warfare are far more extensive than heretofore.

Among the outstanding medical problems which present themselves either during an air raid at home or at the active war front, are the care and treatment of hemorrhage and shock. A symposium has been developed on hemorrhage and shock by Dr. Schmidt in order that members attending the One Hundred First Anniversary Meeting may be refreshed in their basic knowledge of this subject and become familiar with the most recent advances made in this field.

The entire Wednesday afternoon program has been set aside so that Wisconsin physicians might obtain the findings of such outstanding men as Lieutenant Colonel William C. Porter of the United States Army Medical Corps, Dr. George M. Curtis, Columbus, Ohio and Dr. Warren H. Cole, Chicago.

War Exhibits

The Procurement and Assignment Service, together with Emergency Medical Service under Civilian Defense will present exhibits on the entire stage in the Main Arena in the Milwaukee Auditorium. An extensive exhibit will be presented by the Procurement and Assignment Service outlining its work in Wisconsin and an opportunity will be given to members of the Society to obtain authentic information concerning enlistment in the armed forces. An opportunity has been afforded to the Navy and Recruiting Boards to be present at the exhibit to advise and counsel physicians.

Under the joint supervision of Dr. John S. Coulter, Chicago, regional medical officer for the Sixth Civilian Defense Region and Dr. R. E. Fitzgerald, Milwaukee, state chief of Emergency Medical Service, an exhibit portraying the manifold divisions of Emergency Medical Service will also be presented on the stage. Among the subjects to be emphasized by Dr. Coulter and Dr. Fitzgerald will be the medical aspects of chemical warfare, the prescribed first-aid post and casualty station equipment of the Office of Civilian Defense, the function and purposes of nurses' aides and the training and duties of stretcher teams. Physicians will be particularly interested in seeing the decontamination exhibit in which will be found a sniff test set. Here through synthetic odors physicians may acquaint themselves with the odor of poisonous gases used in modern warfare.

Scientific Program

Presented in this issue of *The Journal* is the final program to be presented by recognized teachers, reserve physicians and practicing members of the Society. A total of twenty-eight guest speakers will come to Wisconsin during the three days of the meeting to acquaint Wisconsin physicians with their experiences and findings. The out-of-state physicians who will appear on the program are:

Dr. Erwin R. Schmidt, Madison, who is in charge of the scientific sessions for the meeting.

Dr. H. Kent Tenney, Madison, who will supervise the scientific motion pictures.

A. R. Barnes, Rochester, Minn.
E. T. Bell, Minneapolis, Minn.
B. I. Beverly, Chicago, Ill.
M. L. Blatt, Chicago, Ill.
Willie Mae Clifton, Chicago
Wallace H. Cole, St. Paul, Minn.
Warren H. Cole, Chicago, Ill.
G. M. Curtis, Columbus, O.
H. P. Doub, Detroit, Mich.
G. P. Guibor, Chicago, Ill.
S. W. Harrington, Rochester, Minn.
E. A. Hines, Jr., Rochester, Minn.
H. P. Jenkins, Chicago, Ill.
Julius Jensen, St. Louis, Mo.
C. G. Loosli, Chicago, Ill.
H. O. McPheeters, Minneapolis, Minn.
I. H. Page, Indianapolis, Ind.
T. L. Pool, Rochester, Minn.
Lieutenant Colonel W. C. Porter, Washington, D. C.
F. W. Rankin, Lexington, Ky.
E. H. Rynearson, Rochester, Minn.
W. W. Scott, Chicago, Ill.
G. E. Shambaugh, Jr., Chicago, Ill.
T. D. Spies, Cincinnati, O.
W. W. Spink, Minneapolis, Minn.
O. E. Van Alyea, Chicago, Ill.
J. W. White, New York, N. Y.
R. H. Woods, La Salle, Ill.

In addition over forty members of the State Medical Society of Wisconsin will participate in the program.

Scientific Exhibits

Virtually all members of the Society will recall that the scientific exhibits were first cast in the role of the unwanted stepchild of the scientific program. With advances in the field of visual education, scientific exhibits have kept pace until they now vie with the scientific program in the presentation of postgraduate medical information. It is in these exhibits that valuable information is conveyed to the physician through the senses of touch, sight, hearing and smell.

Enthusiastic commendations were received following the Centennial Anniversary Meeting on the scientific exhibits presented by the University of Wisconsin Medical School and the Marquette University School of Medicine which will again be presented this year. Outstanding at this year's American Medical Association meeting was the exhibit on "Experimental Ameboid Motion of Motor Nerve Plates," which was given the Association's Gold Medal award. Dr. Eben J. Carey, Milwaukee, will present it again at our meeting. The exhibit of Dr. Irwin Schulz of Milwaukee "Wash Wringer Injuries" also received honorable mention at the recent meeting of the American Medical Association. This exhibit was initially shown at the Centennial Meeting of the Society but Dr. Clyde J. Smiles, director of scientific exhibits, requested Dr. Schulz to present his exhibit again. Dr. Norbert Enzer, Milwaukee, will also show his exhibit entitled "Investigations of Sensory and Motor Centers in Fatigue and Disease."

Motion Pictures

Paralleling the scientific exhibits in the employment of visual means of education will be the motion picture portion of the regular scientific program. The Council on

Scientific Work recognized that this means of postgraduate medical education was a specialty in itself and secured Dr. H. Kent Tenney of Madison, who has familiarized himself with the subject of sound motion pictures in the field of medicine, to supervise this feature. The Council on Scientific Work has set aside the first hour of each morning session and the last hour of each afternoon session for the showing of sound scientific motion pictures. On Wednesday morning, which is the time set aside for the several section meetings, a series of motion pictures will be shown simultaneously in several rooms. Members are urged to study the schedule of Wednesday morning scientific motion pictures and attend those which promise to hold the greatest interest for them.

House of Delegates

The increased demand upon the time of the delegates attending the annual meeting impelled the Council on Scientific Work and the Council of the Society to arrange the One Hundred First Anniversary Meeting so that scientific program will fall on Monday, Tuesday and Wednesday, giving the entire day of Sunday for the meeting of the Council and the House of Delegates. This change the Council and the Council on Scientific Work feel will conserve many hours of the physicians' time by making it possible for delegates to attend all meetings of the House of Delegates and avail themselves of the opportunities of the scientific program with the loss of but three days from their practice.

The initial meeting of the House of Delegates will be held on Sunday afternoon at 5 p. m. at the Hotel Schroeder.

Hobby Show

Elsewhere in this issue of *The Journal* full details are given concerning the hobbies which will be displayed in the Main Arena of the Milwaukee Auditorium. All exhibits, scientific, technical, the wartime and hobby, will be shown in one room.

Annual Dinner

The popularity of the annual dinner has grown from year to year. At the Centennial Meeting even the extensive facilities of the Crystal Ballroom in the Loraine Hotel were overtaxed. This condition was anticipated and auxiliary serving facilities were in readiness in an adjacent room. The physical facilities of the Crystal Ballroom of the Hotel Schroeder give every assurance that all will have an opportunity to attend the annual dinner and participate in the festivities.

Dr. F. W. Rankin, president of the American Medical Association, was obtained by Dr. Gunnar Gundersen, president of the State Society. Dr. Rankin has chosen as his subject "The Doctor's Part in the War Program."

By custom those at the speakers table will be attired in formal dinner clothes, whereas other guests will wear business suits or street dresses. The Crystal Ballroom of the hotel will be air-conditioned and every assurance of comfort and a profitable evening awaits those attending this function.

Fred W. Rankin

Meeting High Lights

SUNDAY, SEPTEMBER 13 . . .

P. M.
5:00 House of Delegates—Banquet Room (Fifth Floor), Hotel Schroeder

MONDAY, SEPTEMBER 14 . . .

A. M.
7:30 Registration—Main Arena, Milwaukee Auditorium
8:00 Scientific Motion Pictures—Plankinton Hall, Milwaukee Auditorium
9:00 General Session—Plankinton Hall, Milwaukee Auditorium
10:00 Recess to View Exhibits
10:30 General Session—Plankinton Hall, Milwaukee Auditorium

P. M.
12:10 Round-Table Luncheons—Hotel Schroeder
2:00 General Session—Plankinton Hall, Milwaukee Auditorium
3:00 Recess to View Exhibits
3:30 General Session—Plankinton Hall, Milwaukee Auditorium
6:45 House of Delegates—Crystal Ballroom (Fifth Floor), Hotel Schroeder
8:30 Smoker—Crystal Ballroom (Fifth Floor), Hotel Schroeder

TUESDAY, SEPTEMBER 15 . . .

A. M.
8:00 House of Delegates—Banquet Room (Fifth Floor), Hotel Schroeder
Scientific Motion Pictures—Plankinton Hall, Milwaukee Auditorium
9:00 General Session—Plankinton Hall, Milwaukee Auditorium
10:00 Recess to View Exhibits
10:30 General Session—Plankinton Hall, Milwaukee Auditorium

P. M.
12:10 Round-Table Luncheons—Hotel Schroeder
2:00 General Session—Plankinton Hall, Milwaukee Auditorium
3:00 Recess to View Exhibits
3:30 General Session—Plankinton Hall, Milwaukee Auditorium
6:45 Annual Dinner—Crystal Ballroom, Hotel Schroeder

WEDNESDAY, SEPTEMBER 16 . . .

A. M.
8:00 Scientific Motion Pictures—Milwaukee Auditorium (see schedule page 795)
9:00 Section on Internal Medicine and Cardiology—Plankinton Hall, Milwaukee Auditorium
Section on Obstetrics and Gynecology—Walker Hall, Milwaukee Auditorium
Section on Ophthalmology—Juneau Hall, Milwaukee Auditorium
Section on Orthopedics—North Kilbourn Hall, Milwaukee Auditorium
Section on Pediatrics—South Kilbourn Hall, Milwaukee Auditorium
Section on Radiology—Committee Room D, Milwaukee Auditorium
Section on Surgery—Engelmann Hall, Milwaukee Auditorium
Section on Urology—Committee Room A, Milwaukee Auditorium

P. M.
12:10 Round-Table Luncheons—Hotel Schroeder
2:00 General Session—Plankinton Hall, Milwaukee Auditorium
Section on Otolaryngology—Juneau Hall, Milwaukee Auditorium

OUR GUEST SPEAKERS

Dr. Arlie R. Barnes
Professor of Medicine,
University of Minnesota
Graduate School,
Minneapolis;
The Mayo Clinic,
Rochester, Minnesota

Dr. Stuart W. Harrington
Professor of Surgery,
University of Minnesota
Graduate School,
Minneapolis;
The Mayo Clinic,
Rochester, Minnesota

Walter J. Meek, Ph. D.
Acting Dean and
Professor of Physiology,
University of Wisconsin
Medical School,
Madison, Wisconsin

SUNDAY EVENING, SEPTEMBER 13 . . .

5:00 House of Delegates
Banquet Room (Fifth Floor), Hotel Schroeder

MONDAY MORNING, SEPTEMBER 14 . . .

7:30 Registration
Main Arena, Milwaukee Auditorium

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Diagnosis of Early Syphilis
Diagnosis of Late Syphilis
Management of Syphilis

Symposium on the Heart

9:00 Physiology of Heart and Circulation
Walter J. Meek, Ph.D., acting dean and professor of physiology, University of Wisconsin Medical School, Madison

9:20 Physiologic Principles in Cardiac Diagnosis
Vincent Koch, Janesville

9:40 Diagnosis of Pathologic Conditions of the Heart
Arlie R. Barnes, professor of medicine, University of Minnesota Graduate School, Minneapolis–Rochester; Mayo Clinic, Rochester, Minnesota

10:00 Recess to view exhibits

This time is set aside to give you an opportunity to visit the technical and scientific exhibits. Please stop in and see them.

10:30 Treatment of Cardiac Emergencies in the Home
Francis D. Murphy, clinical professor of medicine, Marquette University School of Medicine, Milwaukee

10:50 Cardiac Treatment at the Hospital
A. G. Koehler, Oshkosh

11:10 Constricting Pericarditis
S. W. Harrington, professor of surgery, University of Minnesota Graduate School, Minneapolis–Rochester; Mayo Clinic, Rochester, Minnesota

11:30 Procurement and Assignment Service

MONDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Registration at each luncheon limited to twenty

Hotel Schroeder

1. Treatment of Painful Feet—How to Meet the Problem
   Robert P. Montgomery, Milwaukee
   Pere Marquette Room
2. Wisconsin Procurement and Assignment Service
   R. E. Fitzgerald, state chairman, Milwaukee
   English Room
3. Medical Participation in Civilian Defense
   a. J. S. Coulter, regional medical officer, Sixth Civilian Defense Region, Chicago
   b. C. O. Vingom, Madison
   c. C. N. Neupert, Madison
   Parlor A
4. Bedside Medicine and Newer Drugs
   O. O. Meyer, associate professor of medicine, University of Wisconsin Medical School, Madison
   Parlor B
5. Cardiac Emergencies in the Home
   Chester M. Kurtz, assistant professor of medicine, University of Wisconsin Medical School, Madison
   Parlor C
6. Amputations and Artificial Limbs
   John O. Dieterle, Milwaukee
   Parlor D
7. Blood Transfusions and Blood Banks
   W. D. Stovall, professor of hygiene, University of Wisconsin Medical School, Madison
   Parlor E
8. What About Vaccines and the Prevention of Common Colds?
   W. M. Nesbit, Madison
   Parlor F
9. Medical Management of Ulcers of the Stomach
   Frederick W. Madison, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee
   Parlor G
10. Refractions in the General Office
    Ferdinand H. Haessler, Milwaukee
    Parlor H
11. Bedside Medicine and Newer Drugs
    Francis D. Murphy, Milwaukee
    Parlor I
12. The Cardiac Problems of the General Practitioner
    Arlie R. Barnes, Rochester, Minnesota
    Pine Room
13. What To Do About Prolonged Labor
    Carl S. Harper, assistant clinical professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison
    Committee Room
14. Toxemia in Pregnancy
    H. W. Shutter, Milwaukee
    Room B
15. Treatment of Skin Diseases in General Practice
    Stephan Epstein, Marshfield
    Room C

16. Surgical Measures in Tuberculosis
    a. A. R. Curreri, assistant professor of surgery, University of Wisconsin Medical School (chairman), Madison
    b. W. H. Oatway, Jr., assistant professor of medicine, University of Wisconsin Medical School, Madison

    Room D

17. Newer Therapy in Poliomyelitis
    a. Herman Wirka, associate professor of orthopedic surgery, University of Wisconsin Medical School (chairman), Madison
    b. Kenneth McDonough, assistant professor of pediatrics, University of Wisconsin Medical School, Madison

    Room E

18. The Use of Drugs in the Treatment of Skin Diseases

    Harry Foerster, assistant professor of dermatology, University of Wisconsin Medical School, Madison, and assistant clinical professor of dermatology, Marquette University School of Medicine, Milwaukee

    Room F

19. Management of Gangrene of the Extremities

    R. T. Cooksey, Madison

    Club Room

20. Medical Problems of the Local Health Officer

    C. A. Harper, state health officer, Madison

    Room 619

MONDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

Symposium on Hemorrhage

2:00 Pathologic Physiology of Hemorrhage
Frederick W. Madison, Milwaukee

2:20 Clinical Failure of Circulation—Hemorrhage and Shock
J. S. Supernaw, Madison

2:40 Treatment—Clinical Failure of Circulation—Shock
Conde F. Conroy, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee

3:00 Recess to view exhibits

> Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

3:30 The Treatment of Obstetrical Hemorrhage
Joseph M. Freeman, Wausau

3:50 The Treatment of Traumatic Hemorrhage
Arthur C. Taylor, Appleton

4:10 The Management of Nontraumatic Hemorrhage
W. A. Killins, Green Bay

4:30 Scientific motion pictures
Otoscopy in the Inflammations

MONDAY EVENING . . .

6:45 House of Delegates
Crystal Ballroom (Fifth Floor), Hotel Schroeder

8:30 Smoker
Crystal Ballroom (Fifth Floor), Hotel Schroeder

ROUND—TABLE RESERVATIONS

If you neglected returning your reservation slip for round-table luncheons, you may make reservation at the time you register. A special attendant will be at the registration desk to assist you. Be certain that you make your reservation at the time you register, if you have not already done so.

OUR GUEST SPEAKERS

Dr. Edward H. Rynearson
Assistant Professor of Medicine, University of Minnesota Graduate School, Minneapolis; The Mayo Clinic, Rochester, Minnesota

Dr. Wesley W. Spink
Associate Professor of Internal Medicine, University of Minnesota Medical School; Assistant Professor of Medicine, University of Minnesota Graduate School, Minneapolis, Minnesota

Dr. Tom D. Spies
Associate Professor of Medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio

Dr. Clayton G. Loosli
Assistant Professor of Medicine University of Chicago School of Medicine, Chicago, Illinois

TUESDAY MORNING, SEPTEMBER 15 . . .

8:00 House of Delegates
Banquet Room (Fifth Floor), Hotel Schroeder

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Appendicitis in Children

Symposium on Sulfonamides

9:00 The Pharmacology of Sulfonamides
Harry Beckman, professor and director, department of pharmacology, Marquette University School of Medicine, Milwaukee

9:20 Sulfonamides in General Practice
Charles E. Pechous, Kenosha

9:40 Sulfonamides in Surgery
Frank D. Weeks, Ashland

10:00 Recess to view exhibits

> The technical exhibits make it possible to present the annual meeting without a registration fee. Express your appreciation to the exhibitors by visiting their booths.

10:30 Procurement and Assignment Service
R. E. Fitzgerald, state chairman, Milwaukee

10:50 Address of Dr. Francis E. Butler, Menominee, incoming president

11:10 The Clinical Applications and Complications of the Sulfonamides
Wesley W. Spink, associate professor of internal medicine, University of Minnesota Medical School, Minneapolis; assistant professor of medicine, University of Minnesota Graduate School, Minneapolis

11:30 Recess to view exhibits

TUESDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Registration at each luncheon limited to twenty

Hotel Schroeder

1. Bedside Medicine and Newer Drugs
   O. O. Meyer, Madison
   Pere Marquette Room
2. The Management of Occiput Posteriors
   E. F. Schneiders, Madison
   Parlor B
3. Early Lesions of the Breast
   Carl Eberbach, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee
   Parlor C
4. Toxemias of Pregnancies
   Henry J. Olson, assistant clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee
   Parlor D
5. Endocrines in Gynecology
   John E. Haberland, Milwaukee
   Parlor E
6. Medical Management of Gallbladder Disease
   a. Harold E. Marsh (chairman), Madison
   b. Wesley W. Spink, Minneapolis
   Parlor F
7. Pneumonia and Its Therapy
   a. Frederick W. Madison (chairman), Milwaukee
   b. Clayton G. Loosli, assistant professor of medicine, University of Chicago School of Medicine, Chicago
   Parlor G
8. The Practical Use of Hormones
   E. H. Rynearson, assistant professor of medicine, University of Minnesota Graduate School, Minneapolis–Rochester; Mayo Clinic, Rochester, Minnesota
   Parlor H
9. Everyday Facts about Vitamins
   Elmer L. Sevringhaus, professor of medicine, University of Wisconsin Medical School, Madison Parlor I
10. Surgery of the Colon
    Joseph M. King, Milwaukee Pine Room
11. Toxoid Immunization for Tetanus
    John E. Gonce, professor of pediatrics, University of Wisconsin Medical School, Madison
    Committee Room
12. Sulfonamides in Genito-Urinary Surgery
    a. Ira R. Sisk, professor of urology, University of Wisconsin Medical School (chairman), Madison Club Room
13. Infant Feeding
    F. R. Janney, assistant clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee; Wauwatosa
    Room B
14. Roentgenology of Spinal Fractures
    Designed especially for general practitioners not having services of a roentgenologist readily available.
    a. John E. Habbe, assistant clinical professor of roentgenology, Marquette University School of Medicine (chairman), Milwaukee
    b. L. W. Paul, associate professor of radiology, University of Wisconsin Medical School, Madison
    Room C
15. Fractures of the Arm
    Herman C. Schumm, associate professor of orthopedic surgery, University of Wisconsin Medical School, Madison, and clinical professor of orthopedic surgery, Marquette University School of Medicine, Milwaukee
    Room D
16. Estimation of Disability in Compensation Cases
    a. Chester C. Schneider (chairman), Milwaukee
    b. Mr. Harry A. Nelson, director, Workmen's Compensation, Industrial Commission, Madison
    Room E
17. Management of Epilepsy
    Theodore C. Erickson, associate professor of surgery, University of Wisconsin Medical School, Madison
    Room F
18. Neurology and Everyday Diagnosis
    a. John L. Garvey, clinical professor of neurology, Marquette University School of Medicine (chairman), Milwaukee
    b. Mabel G. Masten, associate professor of neurology and psychiatry, University of Wisconsin Medical School, Madison
    Room 607
19. Wisconsin Procurement and Assignment Service
    R. E. Fitzgerald, Milwaukee
    English Room
20. Medical Participation in Civilian Defense
    a. J. S. Coulter, Chicago
    b. C. O. Vingom, Madison
    c. C. N. Neupert, Madison
    Parlor A
21. Fractures of Wrist, Humerus, and Ankle
    a. H. Louis Greene (chairman), Madison
    b. J. T. F. Gallagher, Madison
    Room 619
22. Surgery of the Stomach
    F. Gregory Connell, Oshkosh
    Room 707
23. Bedside Medicine and Newer Drugs
    Francis D. Murphy, Milwaukee
    Room 719

TUESDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

2:00 Pneumonia and Chemotherapy
Clayton G. Loosli, Chicago

2:20 The New Prophylactic Measures in Tetanus
Carl N. Neupert, assistant state health officer, Madison

2:40 Resuscitation of the Newborn Infant
William C. Keettel, special postgraduate instructor and adviser in obstetrics and gynecology, State Board of Health, Madison

3:00 Recess to view exhibits

Take this time to visit the technical, scientific and hobby exhibits. The exhibitors will appreciate seeing you.

3:30 Intra-Abdominal Diverticulitis
J. J. Gramling, Jr., Milwaukee

3:50 Actual Clinical Disturbances of the Endocrine Glands
E. H. Rynearson, Rochester, Minnesota

4:10 Advances in Vitamin Therapy
Tom D. Spies, associate professor of medicine, University of Cincinnati College of Medicine, Cincinnati

4:30 Scientific Motion Pictures
Treatment of Breech Presentation

6:45 Annual Dinner—Crystal Ballroom Hotel Schroeder—(Informal)
Speaker—Fred W. Rankin, president of the American Medical Association, Lexington, Ky.

WEDNESDAY MORNING MOTION PICTURE PROGRAM

The scientific motion pictures listed below have been selected particularly by Dr. H. Kent Tenney and the Council on Scientific Work for display in connection with the scientific sections.

8:00

Skin Graft—Plankinton Hall
The above motion picture will be of special interest to the Section on Surgery.

Abdominal Pelvic Operation for Residues of Infection—Walker Hall
Of special interest to the Section on Obstetrics and Gynecology.

First Aid in Transportation of Fractures of Arm, Leg and Spine—North Kilbourn Hall
Of interest to general surgeons, orthopedists and general practitioners.

Dermatoses of Industrial Workers — Engelmann Hall
For dermatologists, internists and industrial surgeons.

8:30

Proctoscopic Cinematography — Plankinton Hall
For those interested in surgery.

Erythroblastic Anemia — South Kilbourn Hall
Of special interest to the Section on Pediatrics.

Emergency Traction for Safe Transportation of Fractures of the Long Bones —North Kilbourn Hall
For those interested in orthopedics or general surgery.

Hypospadias — Surgical Treatment of the Inlaying Graft Method—Walker Hall
Of particular interest to urologists and surgeons.

Direct Laryngoscopy—Engelmann Hall
Of special interest to ophthalmologists and otolaryngologists.

WEDNESDAY MORNING, SEPTEMBER 16 . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00–9:00 Scientific Motion Pictures
Skin Graft
Proctoscopic Cinematography

SECTION ON INTERNAL MEDICINE AND CARDIOLOGY . . .

Dr. Elexious T. Bell

Professor of Pathology, University of Minnesota Medical School, and University of Minnesota Graduate School, Minneapolis, Minnesota

Dr. Edgar A. Hines, Jr.

Assistant Professor of Medicine, University of Minnesota Graduate School, Minneapolis; The Mayo Clinic, Rochester, Minnesota

See schedule of scientific motion pictures of special interest to internists and cardiologists on page 795.

Chairman: G. Hoyme, Eau Claire

Plankinton Hall, Milwaukee Auditorium

Symposium on Hypertension

9:00 The Range of Blood Pressure and Hereditary Factors in Normal and Hypertensive States
E. A. Hines, Jr., assistant professor of medicine, University of Minnesota Graduate School, Minneapolis–Rochester; Mayo Clinic, Rochester, Minnesota

9:30 Blood Pressure in Life Insurance
D. E. W. Wenstrand, medical director, Northwestern Mutual Life Insurance Company, Milwaukee

10:00 **Recess to view exhibits**

Take this time to visit the technical, scientific and hobby exhibits. The exhibitors will appreciate seeing you.

10:30 The Pathology of Hypertension
E. T. Bell, professor of pathology, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis

Dr. Irvine H. Page

Indianapolis, Indiana

10:50 The Mechanism and Experimental Treatment of Hypertension
Irvine H. Page, Indianapolis

11:10 Summary of Facts and Treatment of Hypertension
Francis D. Murphy, Milwaukee

11:30 **Recess to view exhibits**

The hobby show is located in the main arena. Be sure and see it and the technical and scientific exhibits.

WEDNESDAY MORNING, SEPTEMBER 16 . . .

SECTION ON OBSTETRICS AND GYNECOLOGY . . .

Dr. Julius Jensen
Assistant Professor of Clinical Medicine, Washington University School of Medicine, St. Louis, Missouri

Films of special interest to obstetricians will be found on page 795.

Chairman: Francis M. Frechette, Janesville
Walker Hall, Milwaukee Auditorium

9:00 Implantation of a New Pituitary Gonadotropic Hormone with Results in a Series of Cases
John Dale Owen, clinical instructor in obstetrics and gynecology, Marquette University School of Medicine, Milwaukee
Discussant:
9:20 J. W. Lambert, Antigo

9:30 The Use of Sulfonamides in Obstetrics
D. M. Gallaher, Appleton
Discussant:
9:50 Woodruff Smith, Ladysmith

10:00 Recess to view exhibits

Take this time to visit the technical, scientific and hobby exhibits. The exhibitors will appreciate seeing you.

10:30 The Management of Toxemia in the Last Trimester of Pregnancy
Warner S. Bump, Rhinelander
Discussant:
10:50 J. W. McGill, Superior

11:00 Modern Concepts of the Relation between Heart Disease and Pregnancy
Julius Jensen, assistant professor of clinical medicine, Washington University School of Medicine, St. Louis
Discussant:
11:20 Thomas O. Nuzum, Janesville

11:30 Recess to view exhibits

The hobby show is located in the main arena. Be sure and see it and the technical and scientific exhibits.

SECTION ON ORTHOPEDICS . . .

See schedule of scientific motion pictures of special interest to orthopedists on page 795.

Chairman: Walter P. Blount, Milwaukee
North Kilbourn Hall, Milwaukee Auditorium

9:00 The Treatment of Painful Feet in General Practice
Robert P. Montgomery, Milwaukee
Discussants:
9:20 David J. Ansfield, Milwaukee
Charles M. Ihle, Eau Claire

9:30 The Modern Treatment of Acute Osteomyelitis
A. C. Schmidt, Milwaukee
Discussants:
9:50 John O. Dieterle, Milwaukee
Lemuel D. Smith, Milwaukee

10:00 Recess to view exhibits

10:30 The Kenny Treatment of Anterior Poliomyelitis
Wallace H. Cole, professor of surgery and director of division of orthopedic surgery, University of Minnesota Medical School, and University of Minnesota Graduate School, Minneapolis
Discussants:
10:50 Walter P. Blount, Milwaukee
Robert E. Burns, professor of orthopedic surgery, University of Wisconsin Medical School, Madison

11:00 Reconstruction Surgery for the Sequelae of Anterior Poliomyelitis
Herman Wirka, Madison
Discussants:
11:20 Herman C. Schumm, Milwaukee
H. Louis Greene, Madison

11:30 Recess to view exhibits

SECTION ON OPHTHALMOLOGY . . .

Dr. James W. White
Clinical Professor of Ophthalmology, New York Postgraduate Medical School, Columbia University, New York, New York

Dr. George P. Guibor
Chicago, Illinois

Films of special interest to ophthalmologists are listed on page 795.

Dr. Ralph H. Woods
La Salle, Illinois

Chairman: R. O. Ebert, Oshkosh

Juneau Hall, Milwaukee Auditorium

9:00 The Practical Use of Prisms
George P. Guibor, Chicago

Discussant:
9:20 Aubrey H. Pember, Janesville

9:30 The Treatment of Amblyopia
I. Franklin, Milwaukee

Discussant:
9:50 F. H. Haessler, Milwaukee

10:00 Recess to view exhibits

The hobby show is located in the main arena. Be sure and see it and the technical and scientific exhibits.

10:30 Diagnosis in Diseases of Eye Muscles
James W. White, clinical professor of ophthalmology, New York Postgraduate Medical School, Columbia University, New York

Discussant:
10:50 E. J. Zeiss, Appleton

11:00 Frequent Causes of Eye Discomfort
Ralph H. Woods, La Salle, Illinois

Discussant:
11:20 Leopold J. Friend, Beloit

11:30 Recess to view exhibits

Take this time to visit the technical, scientific and hobby exhibits. The exhibitors will appreciate seeing you.

WEDNESDAY MORNING, SEPTEMBER 16 . . .

SECTION ON PEDIATRICS . . .

Dr. Bert Beverly
Assistant Clinical Professor of Pediatrics, Rush Medical College, University of Chicago, Chicago, Illinois

Dr. Maurice Blatt
Professor of Pediatrics, University of Illinois College of Medicine, Chicago, Illinois

See schedule of scientific motion pictures of special interest to pediatricians on page 795.

Chairman: F. R. Janney, assistant clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee; Wauwatosa

South Kilbourn Hall, Milwaukee Auditorium

9:00 Recent Advances in the Treatment of Meningitis
V. J. Cordes, Wauwatosa
Discussants:
9:20 Henry Sincock, Superior
John E. Gonce, Madison

9:30 Electroencephalography in Pediatrics
M. G. Peterman, Milwaukee
Discussants:
9:50 Hans W. Hefke, Milwaukee
Theodore C. Erickson, Madison

10:00 Recess to view exhibits

The hobby show is located in the main arena. Be sure and see it and the technical and scientific exhibits.

10:30 Control of Contagion in Childhood
Maurice Blatt, professor of pediatrics, University of Illinois College of Medicine, Chicago
Discussants:
10:50 R. P. Schowalter, assistant clinical professor of medicine, Marquette University School of Medicine, Milwaukee
E. R. Krumbiegel, city health commissioner, Milwaukee

11:00 Emotional States and Management Problems in Childhood
Bert Beverly, assistant clinical professor of pediatrics, Rush Medical College, University of Chicago, Chicago
Discussants:
11:20 Eugenia S. Cameron, State Board of Health, Madison
H. Kent Tenney, associate professor of pediatrics, University of Wisconsin Medical School, Madison

11:30 Recess to view exhibits

Don't fail to see the fine display of technical, scientific and hobby exhibits in the main arena.

EXHIBITS IN MAIN ARENA

All of the facilities of the Milwaukee Auditorium will be devoted to exhibits of a varied character,—scientific, technical, hobby and wartime exhibits. This means of postgraduate medical education has demonstrated its effectiveness.

The technical exhibits make possible your attendance at the One Hundred First Anniversary Meeting without payment of a registration fee. If it were not for these exhibitors, it would be necessary to charge a minimum registration fee of from $4 to $5. All of the exhibitors have a genuine message for you. You will be well repaid if you will stop at their booths.

SECTION ON RADIOLOGY . . .

Dr. Howard P. Doub
Detroit, Michigan

Films of special interest to radiologists are listed on page 795.

Chairman: L. W. Paul, associate professor of radiology, University of Wisconsin Medical School, Madison

Committee Room D, Milwaukee Auditorium

9:00 Case Reports
H. W. Hefke, Milwaukee
W. T. Clark, Janesville
Theodore Sokow, Kenosha
L. V. Littig, Madison
T. J. Pfeffer, Racine
I. G. Ellis, Madison
R. P. Potter, Marshfield
E. A. Pohle, Madison

10:00 Recess to view exhibits

Don't fail to see the fine display of technical, scientific and hobby exhibits in the main arena.

10:30 A Technic for Iodized Oil Myelography
S. A. Morton, Milwaukee
Discussants:
10:50 E. E. Seedorf, La Crosse
L. V. Littig, Madison

11:00 The Roentgenographic Changes in Virus Pneumonia
Howard P. Doub, Henry Ford Hospital, Detroit
Discussants:
11:20 R. P. Potter, Marshfield
S. R. Beatty, Oshkosh

11:30 Recess to view exhibits

SECTION ON SURGERY . . .

Dr. Hilger P. Jenkins
Associate Professor of Surgery,
University of Chicago,
The School of Medicine,
Chicago, Illinois

See schedule of scientific motion pictures of special interest to surgeons on page 795.

Chairman: Albert Tormey, Madison

Engelmann Hall, Milwaukee Auditorium

9:00 Appendicitis: Thirty-Five Year Survey in Rock County
W. A. Munn, Janesville
T. J. Snodgrass, Janesville
T. H. Flarity, Beloit

Dr. Herman O. McPheeters
Minneapolis, Minnesota

Discussants:
9:20 Paul F. Doege, Marshfield
M. H. Wirig, Madison

9:30 Problems in the Selection, Preparation, and Use of Suture Material in General Surgery
Hilger P. Jenkins, associate professor of surgery, University of Chicago, School of Medicine, Chicago

Discussant:
9:50 C. W. Eberbach, Milwaukee

WEDNESDAY MORNING, SEPTEMBER 16 . . .

10:00 Recess to view exhibits

> Don't fail to see the fine display of technical, scientific and hobby exhibits in the main arena.

10:30 Cesarean Section
Roland S. Cron, clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee
Discussants:
10:50 William C. Keettel, Madison
E. F. Schneiders, Madison

11:00 The Present Day Treatment of Varicose Veins
H. O. McPheeters, Minneapolis
Discussants:
11:20 George G. Stebbins, Madison
Matthew A. McGarty, La Crosse

11:30 Recess to view exhibits

> The hobby show is located in the main arena. Be sure and see it and the technical and scientific exhibits.

SECTION ON UROLOGY . . .

Dr. Thomas L. Pool
Mayo Clinic,
Rochester, Minnesota

> See schedule of scientific motion pictures of special interest to urologists on page 795.

Chairman: I. R. Sisk, Madison
Committee Room A, Milwaukee Auditorium

9:00 Present Day Status of Hormonal Treatment for Urologic Conditions
Walter M. Kearns, Milwaukee
Discussant:
9:20 George Ewell, Madison

9:30 Castration Treatment of Carcinoma of the Prostate
W. W. Scott, Chicago
Discussant:
9:50 Charles Marquardt, assistant clinical professor of urology, Marquette University School of Medicine, Milwaukee

10:00 Recess to view exhibits

> Don't fail to see the fine display of technical, scientific and hobby exhibits in the main arena.

10:30 The Treatment of Urinary Tract Infections with the Sulfonamide Group of Drugs
T. L. Pool, Mayo Clinic, Rochester, Minnesota
Discussant:
10:50 H. M. Stang, Eau Claire

11:00 Report of Prostatic Surgery at the Wisconsin General Hospital in 1940–1941
Ira R. Sisk, Madison
Discussant:
11:20 Alexander D. Spooner, Milwaukee

11:30 Recess to view exhibits

> Be sure to visit the Procurement and Assignment Service booth on the stage in the main arena of the Milwaukee Auditorium.

TELEPHONE SERVICE AT AUDITORIUM

Your telephone number at the Milwaukee Auditorium will be Broadway 8030. When you leave to attend sessions of the One Hundred First Anniversary Meeting, leave word at your home and office that you can be reached at that number.

WEDNESDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Registration at each luncheon limited to twenty

Hotel Schroeder

1. Cardiac Risks in Obstetrics
   Julius Jensen, St. Louis
   Room 719
2. Sutures in Surgery
   Hilger P. Jenkins, Chicago
   Parlor B
3. Injection of Varicose Veins
   H. O. McPheeters, Minneapolis
   Parlor C
4. Cesarean Section
   Roland Cron, Milwaukee
   Parlor D
5. Orthopedics in Children
   a. Walter P. Blount (chairman), Milwaukee
   b. Wallace H. Cole, St. Paul
   Parlor E
6. Control of Contagion in Childhood
   Maurice Blatt, Chicago
   Parlor F
7. The Roentgenographic Aspects of Diseases Affecting the Spinal and Intervertebral Discs
   H. P. Doub, Detroit
   Parlor G
8. The Mechanism and Experimental Treatment of Hypertension
   Irvine H. Page, Indianapolis
   Parlor H
9. The Etiology of Primary Hypertension
   E. T. Bell, Minneapolis
   Parlor I
10. The Prevention and Treatment of Thrombosis and Embolism
    E. A. Hines, Jr., Rochester, Minnesota
    Pine Room
11. Mutual Problems in Life Insurance Examinations
    D. E. W. Wenstrand, Milwaukee
    Committee Room
12. Carcinoma of the Prostate
    W. W. Scott, Chicago
    Banquet Room (rear)
13. Sinusitis and Its Management
    O. E. Van Alyea, Chicago
    Room B
14. Recent Advances in Human Blood Typing
    a. Norbert Enzer (chairman), Milwaukee
    b. I. Davidsohn, Chicago
    Room C
15. Wisconsin Procurement and Assignment Service
    R. E. Fitzgerald, Milwaukee
    English Room
16. Medical Participation in Civilian Defense
    a. J. S. Coulter, Chicago
    b. C. O. Vingom, Madison
    c. C. N. Neupert, Madison
    Parlor A
17. Rheumatism
    a. Milton C. Borman (chairman), Milwaukee
    b. Vincent Koch, Janesville
    Room 609
18. Drugs in Skin Diseases
    Harry R. Foerster, Milwaukee
    Room E
19. Management of Occiput Posteriors
    Benjamin E. Urdan, assistant clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee
    Room F
20. Hospital Administration and Practice of Medicine
    Harry W. Sargeant, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee; Milwaukee County Hospital, Wauwatosa
    Pere Marquette Room
21. Surgical Emergencies
    Albert Tormey, Madison
    Room 607
22. Hematological Aids in Pediatric Diagnosis
    Willie Mae Clifton, Chicago
    Room 707
23. Past-Presidents' Luncheon
    Room D

WEDNESDAY AFTERNOON . . .

GENERAL SESSION . . .

Dr. Warren H. Cole
Professor of Surgery,
University of Illinois
College of Medicine,
Chicago, Illinois

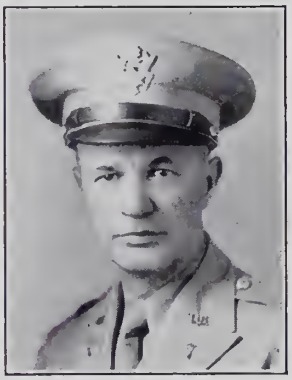
Dr. George M. Curtis
Professor of Surgery,
Ohio State University,
College of Medicine,
Columbus, Ohio

Plankinton Hall, Milwaukee Auditorium

2:00 Theresa Rogers Memorial Lecture—War and Neuropsychiatry
Lt. Col. William C. Porter, Medical Corps, U. S. Army, Walter Reed General Hospital, Washington, D. C.

2:30 Blast Injuries
George M. Curtis, professor of surgery, department of research surgery, Ohio State University College of Medicine, Columbus, Ohio.

3:00 The Treatment of Civilian War Injuries
Warren H. Cole, professor of surgery, University of Illinois College of Medicine, Chicago



Lieutenant Colonel
William C. Porter
Medical Corps, U.S. Army
Walter Reed General
Hospital
Washington, D. C.

THE WAR EXHIBITS

On the stage in the Main Arena of the Milwaukee Auditorium will be an extensive exhibit prepared by the Procurement and Assignment Service in which its work will be portrayed and an opportunity given to members of the Society to obtain authentic information concerning enlistment in the armed forces.

In addition, there will be a booth devoted to Emergency Medical Service, presented under the joint supervision of Dr. John S. Coulter, Chicago, regional medical officer for the Sixth Civilian Defense Region, and Dr. R. E. Fitzgerald, Milwaukee, state chief of Emergency Medical Service. In this exhibit, members may become familiar with the odors of various gases used in warfare through the "sniff test." Gas masks and clothing will be displayed and technical information will be given on the effect of war gases on the human body.

Medical supplies and equipment outlined in Medical Division Bulletin #2 of the Office of Civilian Defense will be displayed, and the exhibit will include first-aid post units, casualty station units, stretcher insert racks, Thomas splints and similar facilities. A special section of the booth will be devoted to the Wisconsin Nursing Council for War Service and Miss Mildred Fehlhauer, nurse deputy to the state chief of Emergency Medical Service, will be in charge.

SECTION ON OTOLARYNGOLOGY . . .

Dr. George E. Shambaugh, Jr.
Associate Clinical Professor of Laryngology and Otolaryngology, Rush Medical College, University of Chicago
Chicago, Illinois

Dr. Oliver E. Van Alyea
Chicago, Illinois

Chairman: R. O. Ebert, Oshkosh
Juneau Hall, Milwaukee Auditorium

2:00 Sulfonamides in Eye, Ear, Nose and Throat
James W. Tanner, Eau Claire
Discussant:
2:20 R. C. Lowe, Neenah

2:30 Plastic Surgery of the Head
Volney B. Hyslop, professor of oral and plastic surgery, University of Wisconsin Medical School, Madison
Discussant:
2:50 G. V. I. Brown, emeritus professor of plastic surgery, University of Wisconsin Medical School, Madison; Milwaukee

3:00 Recess to view exhibits

The technical exhibits make it possible to present the annual meeting without a registration fee. Express your appreciation to the exhibitors by visiting their booths.

3:30 Allergy in Office Eye, Ear, and Throat Practice
George E. Shambaugh, Jr., associate clinical professor of laryngology and otolaryngology, Rush Medical College, University of Chicago, Chicago
Discussant:
3:50 George L. McCormick, Marshfield

4:00 Treatment of Acute Infections of the Nose and Sinuses
O. E. Van Alyea, Chicago
Discussant:
4:20 Otis M. Wilson, Wausau

4:30 Indications for Bronchoscopy
John D. Steele, Milwaukee
Discussant:
4:50 A. V. Cadden, Wauwatosa

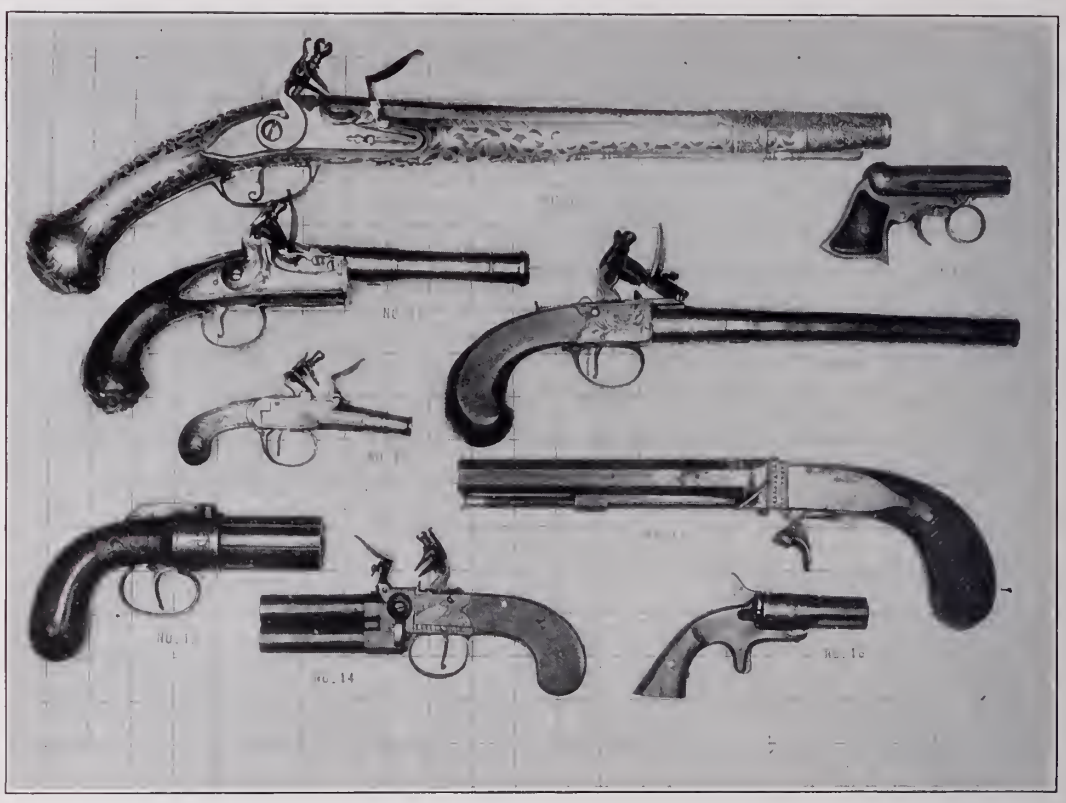
Members—1942 House of Delegates

Society	*Delegate*	*Alternate Delegate*
Ashland–Bayfield–Iron	R. O. Grigsby, Ashland	C. J. Smiles, Ashland
Barron–Washburn–Sawyer–Burnett	D. L. Dawson, Rice Lake	S. O. Lund, Cumberland
Brown–Kewaunee–Door	P. R. Minahan, Green Bay	W. W. Kelly, Green Bay
	O. A. Stiennon, Green Bay	W. E. Leaper, Green Bay
Calumet	F. P. Knauf, Kiel	N. J. Knauf, Chilton
Chippewa	A. J. Somers, Chippewa Falls	J. J. Sazama, Bloomer
Clark	M. C. Rosekrans, Neillsville	H. H. Christofferson, Colby
Columbia–Marquette–Adams	H. M. Caldwell, Columbus	L. V. McNamara, Montello
Crawford	C. A. Armstrong, Prairie du Chien	H. H. Kleinpell, Prairie du Chien
Dane	A. R. Tormey, Madison	S. A. McCormick, Madison
	H. E. Marsh, Madison	A. J. Boner, Madison
	Louis Fauerbach, Madison	L. R. Cole, Madison
	A. T. Smedal, Stoughton	N. A. Hill, Madison
Dodge	A. G. Hough, Beaver Dam	W. E. Bargholtz, Reeseville
Douglas	T. J. O'Leary, Superior	H. J. Orchard, Superior
Eau Claire–Dunn–Pepin	J. C. Baird, Eau Claire	R. N. Leasum, Osseo
Fond du Lac	D. J. Twohig, Fond du Lac	J. C. Devine, Fond du Lac

MEMBERS—1942 HOUSE OF DELEGATES (Continued)

Society	*Delegate*	*Alternate Delegate*
Forest	G. E. Carroll, Laona	H. C. Marsh, Crandon
Grant	E. H. Spiegelberg, Boscobel	J. H. Fowler, Lancaster
Green	F. J. Bongiorno, Albany	L. E. Creasy, Monroe
Green Lake–Waushara	J. A. Kelly, Green Lake	H. C. Koch, Berlin
Iowa	S. B. Marshall, Hollandale	H. M. Walker, Dodgeville
Jefferson	G. E. Eck, Lake Mills	O. F. Dierker, Watertown
Juneau	C. A. Vogel, Elroy	A. R. Kaufman, Mauston
Kenosha	G. C. Schulte, Kenosha	W. C. Stewart, Kenosha
La Crosse	F. A. Douglas, La Crosse	A. H. Gundersen, La Crosse
Lafayette	W. B. Williams, Argyle	P. W. Leitzell, Benton
Langlade	C. E. Zellmer, Antigo	W. P. Curran, Antigo
Lincoln	R. G. Baker, Tomahawk	F. C. Lane, Merrill
Manitowoc	E. C. Cary, Reedsville	T. H. Rees, Manitowoc
Marathon	J. F. Smith, Wausau	E. E. Flemming, Wausau
Marinette–Florence	A. T. Nadeau, Marinette	H. W. Haasl, Peshtigo
Milwaukee	J. W. Truitt, Milwaukee	L. J. Van Hecke, Milwaukee
	E. L. Bernhart, Milwaukee	H. J. Farrell, Milwaukee
	J. W. Smith, Milwaukee	J. P. Conway, Milwaukee
	E. J. Carey, Milwaukee	J. J. Pink, Milwaukee
	R. A. Toepfer, West Allis	Aaron Yaffe, Milwaukee
	D. F. Pierce, Hales Corners	J. R. Regan, Milwaukee
	S. M. Markson, Milwaukee	G. S. Flaherty, South Milwaukee
	J. C. Griffith, Milwaukee	U. E. Gebhard, Milwaukee
	C. R. Marquardt, Milwaukee	M. C. Borman, Milwaukee
	Charles Fidler, Milwaukee	B. P. Churchill, Milwaukee
	Irwin Schulz, Milwaukee	M. W. Sherwood, Milwaukee
	W. M. Kearns, Milwaukee	J. E. Mulsow, Milwaukee
	C. M. Echols, Milwaukee	C. F. Conroy, Milwaukee
	W. A. Ryan, Milwaukee	F. X. McCormick, Milwaukee
	Norbert Enzer, Milwaukee	C. C. Schneider, Milwaukee
	R. F. Purtell, Milwaukee	Benjamin Lieberman, Milwaukee
	R. E. Galasinski, Milwaukee	W. L. MacKedon, Milwaukee
Monroe	C. S. Phalen, Sparta	Not reported
Oconto	A. F. Slaney, Oconto	C. R. Kwapy, Oconto
Oneida–Vilas	W. S. Bump, Rhinelander	I. E. Schiek, Rhinelander
Outagamie	G. W. Carlson, Appleton	D. W. Curtin, Little Chute
Pierce–St. Croix	Chalmer Davee, River Falls	A. E. McMahon, Menomonie
Polk	L. O. Simenstad, Osceola	K. F. Johnson, Frederic
Portage	E. E. Kidder, Stevens Point	R. J. Stollenwerk, Stevens Point
Price–Taylor	J. D. Leahy, Park Falls	H. B. Norviel, Phillips
Racine	T. C. Hemmingsen, Racine	E. J. Schneller, Racine
Richland	George Parke, Sr., Viola	G. H. Benson, Richland Center
Rock	H. E. Kasten, Beloit	R. A. Thayer, Beloit
	W. A. Munn, Janesville	W. T. Clark, Janesville
Rusk	L. M. Lundmark, Ladysmith	W. F. O'Connor, Ladysmith
Sauk	A. C. Edwards, Baraboo	F. R. Winslow, Baraboo
Shawano	A. A. Cantwell, Shawano	O. F. Partridge, Mattoon
Sheboygan	C. J. Weber, Sheboygan	A. C. Radloff, Plymouth
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Whitehall	Robert Krohn, Black River Falls
Vernon	W. M. Trowbridge, Whitehall	J. J. Rouse, Hillsboro
Walworth	E. D. Sorenson, Elkhorn	D. H. Jeffers, Lake Geneva
Washington–Ozaukee	J. G. Hoffmann, Hartford	O. J. Hurth, Cedarburg
Waukesha	J. C. Hassall, Oconomowoc	R. E. Davies, Waukesha
Waupaca	A. M. Christofferson, Waupaca	J. H. Murphy, Clintonville
Winnebago	R. A. Jensen, Menasha	A. G. Koehler, Oshkosh
Wood	K. H. Doege, Marshfield	F. X. Pomainville, Wis. Rapids
Section on Cardiology	A. W. Bryan, Madison	F. D. Murphy, Milwaukee
Section on Ophthalmology and Otolaryngology	J. K. Trumbo, Wausau	A. H. Pember, Janesville
Section on Orthopedics	H. L. Greene, Madison	R. P. Montgomery, Milwaukee
Section on Radiology	J. E. Habbe, Milwaukee	L. V. Littig, Madison

The House of Delegates will meet on three occasions during the course of the meeting. The first session will convene at 5:00 p. m., Sunday, September 13; the second at 6:45 p. m., Monday, September 14; and the final session at 8:00 a. m., Tuesday, September 15.



The above picture shows some of the guns to be shown by Dr. Paul Doege of Marshfield in the Physicians' Hobby Show at the One Hundred First Anniversary Meeting.

Interesting Hobby Exhibits and Demonstrations to Be Featured In the Exhibit Hall

OVER eighteen physicians will display and demonstrate their hobbies during the course of the One Hundred First Anniversary Meeting. An entire section of the exhibit hall has been set aside for a display of their handicraft. Special demonstrations will be held during recess periods from 10:00 to 10:30 and 11:30 to 12:00 each morning, and from 3:00 to 3:30 each afternoon.

The following members of the Society are scheduled for the physicians' hobby exhibit:

E. T. Ackerman, Gays Mills

During the recess periods Dr. Ackerman will demonstrate his sleight of hand and magic tricks, and will exhibit some of the equipment used.

R. G. Arveson, Frederic

Dr. Arveson will display a large number of bells selected from his collection of 500 which he has acquired from many countries during the last several years. Bells of wood, metal, bone and glass will be shown.

J. J. Barrock, Milwaukee

Dr. Barrock will exhibit in sheet form commemorative stamps, of which he has over 100. Other outstanding stamps to be shown are imperforated stamps of the World's Fair, Admiral Byrd, the national parks, and others.

Paul Doege, Marshfield

For many years Dr. Doege has collected guns, and he now has a collection which portrays the evolution of firearms over the last 600 years. In this exhibit will be Rose locks, Flint locks and others. The progressive stages of development of firearms from crude instruments to our present day, highly de-

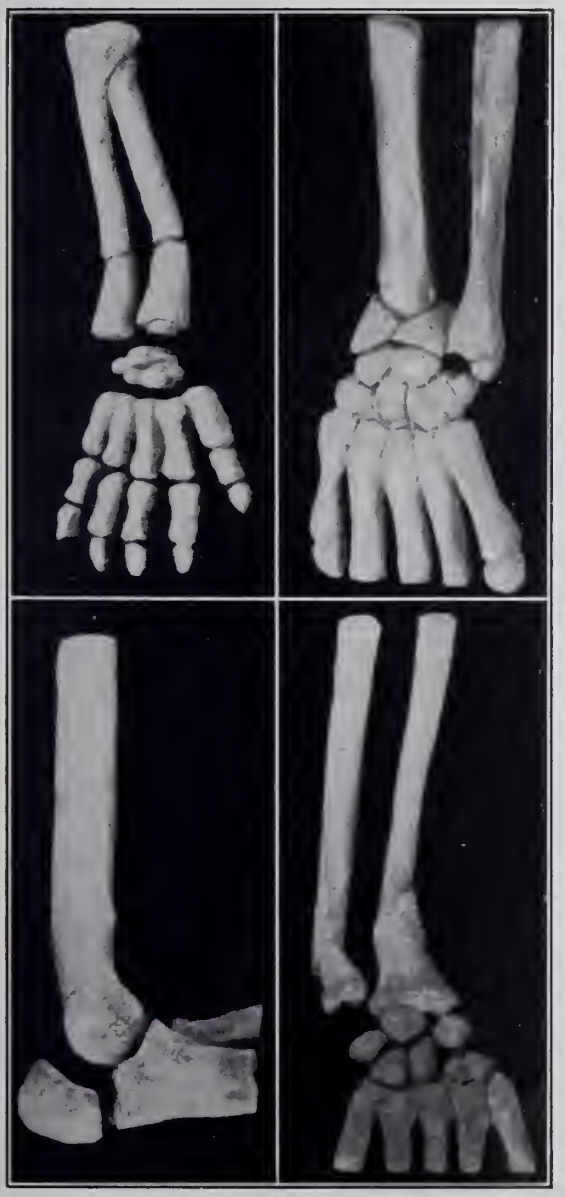
veloped firearm will be shown. Emphasis has been placed by Dr. Doege on a complete display of the Colt firearms.

C. M. Echols, Milwaukee

A varied collection of sea shells will be arranged for display by Dr. Echols.

R. O. Grigsby, Ashland

Arrangements have been made for a booth in which will be located an automatic projector for the showing of kodachrome (natural color) slides. As one of the exhibitors in this booth, Dr. Grigsby will show natural colored, flower slides.



Soap carvings of bone fractures by Dr. A. V. de Neveu of Milwaukee.

Maurice Hardgrove, Milwaukee

Before leaving for military service Dr. Hardgrove made arrangements for the showing of one of his oil paintings entitled "A Barge on the River" and a water color entitled "Red Room."

Arnold Jackson, Madison

A separate motion picture booth for the showing of several hundred feet of flower motion pictures has been arranged for Dr. Jackson.

H. J. Lee, Oshkosh

Substituting a camera for a firearm, Dr. Lee has attained recognition as an outstanding photographer of waterfowl. His collection of pictures is the result of several years' effort at blinds in Wisconsin, Canada and southern states.

S. Megna, Milwaukee

A wide variety of fine glassware has been collected by Dr. Megna, and Dr. C. J. Smiles of Ashland, director of exhibits, is particularly pleased to have it available for display at the annual meeting. Dr. Megna will also show an extensive collection of continental porcelain figures, groups, vases and plates.

W. J. Meek, Madison

A number of pieces of pewter ware will be shown by Dr. Meek, the acting dean of the University of Wisconsin Medical School. Some of the pieces are from an old collection whereas others will be those he made himself.

A. V. de Neveu, Milwaukee

An unusual display will be that of fractured bones carved from soap, the handwork of Dr. de Neveu. In addition, he will display three pastels (chalk) and one oil painting.

Albert Popp, Milwaukee

Exhibit space has been reserved for Dr. Popp's collection of French-Canadian medical journals and French books.

M. G. Peterman, Milwaukee

At the exhibit devoted to the display of natural-color slides (kodachromes) Dr. Peterman will show upwards of fifty pictures.

E. B. Pfefferkorn, Oshkosh

A large collection of Wisconsin wild-life specimens will be shown by Dr. Pfefferkorn in the hobby

exhibit. Those who have had the opportunity of seeing this exhibit in his home have called it "a one-man, wild-life museum." Among the stuffed animals to be displayed will be ducks, mink, loon, coon, fox, rabbits, gophers and owls.

C. J. Smiles, Ashland

The exhibit of the director of scientific exhibits will be demonstrative of two of his hobbies, the first the collection of old medical books and the second, kodachrome photography.

J. F. Smith, Wausau

Present day photography makes it possible to have natural color photographs in the exact colors seen by the eye. Dr. Smith will display six natural-color pictures of fall scenes taken in Wisconsin.

B. L. von Jarchow, Racine

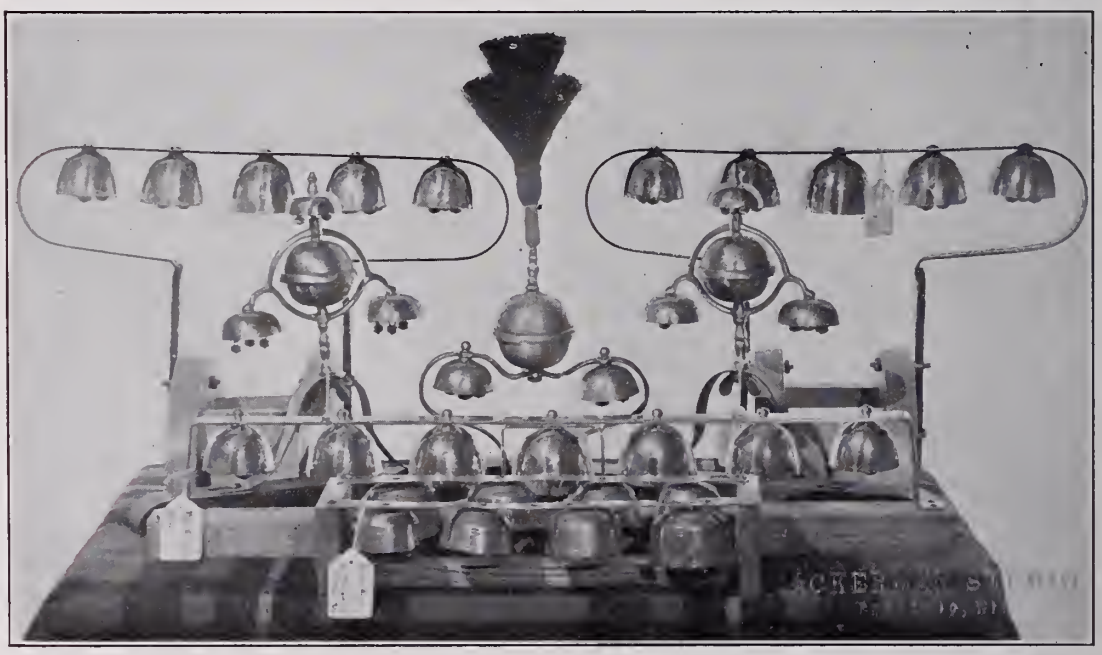
Two of several hobbies of Dr. von Jarchow, paintings and photography, will be shown. These paintings and still photography are devoted to wild life. Colored slides will also be shown on "Wild Flowers in Wisconsin," "Hawks of Wisconsin" and "Water Lilies."

D. E. W. Wenstrand, Milwaukee

Several paintings and sketches will be displayed by Dr. Wenstrand.

A portion of the taxidermy exhibit on wild life to be shown in the Hobby Show by Dr. E. B. Pfefferkorn, Oshkosh.

These exhibits will be both interesting and instructive. Members of the Society in attendance at the meeting are urged to see the hobbies in which their colleagues find relaxation.



Part of a collection of bells to be exhibited by Dr. R. G. Arveson (past-president and councilor, tenth district) in the Hobby Show at the One Hundred First Anniversary Meeting. Shaft bells in foreground were presented to Dr. F. G. Johnson, Sr., Iron River (councilor, eleventh district), by Mrs. Johnson on Christmas, 1893.

Dr. Clyde J. Smiles of Ashland is the member of the Council on Scientific Work who was chosen this year to direct the scientific exhibits for the annual meeting.

THE SCIENTIFIC EXHIBITS

The scientific exhibits, once regarded as the unimportant stepchild of the annual meeting, have now won for themselves a definite place in postgraduate medical education. Initially these exhibits were assigned space that was not desired for any other activity and left to shift for themselves.

Today the picture is different. Now the Council on Scientific work assigns one of its members to the development of this important portion of the meeting and throughout the year the director of scientific exhibits (this year Dr. C. J. Smiles of Ashland) studies the list of known exhibits and selects those that will correlate most closely with the material which will be presented at the scientific sessions.

Through the senses of sight, hearing, touch and smell, those attending the meeting are able to acquaint themselves with the newer developments in the diagnosis and treatment of disease. In the exhibits this year members will have an opportunity to relive, if but for a few moments, their experiences in the dissecting room by visiting the combined Applied Anatomy exhibit of the Marquette University School of Medicine and the University of Wisconsin Medical School.

Select the exhibits you will want to visit from the descriptions given below. Note the ones that interest you and plan to see them.

BOOTH 1

Medical Literature

Medical Library Service

A feature of this year's exhibit will be a collection of books and articles on the subject of military medicine. Representative new books on general medical subjects will be displayed together with new and representative journals. Book lists showing additions to the library for the last year and letters explaining the extension loan system will be distributed to physicians visiting the booth.

BOOTHS 2, 3 AND 4

Early Diagnosis of Tuberculosis by Radiography

Wisconsin Anti-Tuberculosis Association

The new photo-fluorographic unit of the Wisconsin Anti-Tuberculosis Association is the first trailer-mounted 35 mm. unit in the country and is used in traveling tuberculosis clinics throughout Wisconsin. Twenty-seven feet long, the trailer will be rolled into the auditorium for display, along with comparison films of the same individual taken by means of the 35 mm., 4x5 and 14x17 equipment. An x-ray technician will be on hand to take chest x-rays of convention visitors to show the screening process in action.

Particularly adaptable for tuberculosis surveys in large groups, the photo-fluorograph's main purpose is to separate the normal from the suspicious cases. It is now being used in industrial defense plant surveys. After the films are developed and processed, they are placed in a special enlarging device for interpretation by the W.A.T.A. physicians. When any irregularities are found, the patient is advised to have a full sized x-ray taken for further study.

The trailer itself is divided into four main sections: the conference room where the medical social history is taken; two dressing rooms; and a small storage and darkroom.

This is the second trailer unit to be utilized by the W.A.T.A. in early diagnosis work. The first, a fluoroscopic unit, has been in service since 1939.

BOOTHS 5, 12 AND 13

Radiographic Studies

Wisconsin Roentgen Ray Society

This exhibit consists of films illustrating various roentgenologic problems. It is presented by the

various members of the Society and includes a display of "Easily Missed Fractures" and other subjects of general interest.

BOOTH 6

Dietary Deficiency Diseases

American Medical Association, Chicago

This exhibit from the Council on Foods and Nutrition of the American Medical Association includes a large number of transparencies in color showing typical deficiency diseases resulting from the lack of vitamin A, thiamine, niacin, riboflavin, ascorbic acid, calcium and the like. Charts present in tabular form the best sources of various dietary essentials and what percentage of the day's requirement may be found in an ordinary serving of various foods. The green, leafy and yellow vegetables are outstanding sources of vitamin A. Thiamine is contained in abundance in pork and dried brewer's yeast; other sources of less value are the nutritionally unimpaired cereals and meats. Niacin (nicotinic acid) is found commonly in meats, especially liver. Riboflavin is also found in large amounts in liver, with milk as the most important common source. Ascorbic acid is contained in large amounts in the citrus fruits and to a lesser extent in many of the other fruits and vegetables. Protein is obtained best from animal foods, calcium from milk and iron from the green leafy vegetables and meat.

BOOTHS 7 AND 8

Obstetric Manikin Demonstrations

Wisconsin Society of Obstetrics and Gynecology

The exhibit was prepared by Dr. Walter Zeit of the anatomy department of the Marquette University School of Medicine and is a graphic dissection of the female pelvis with particular emphasis on the muscle and fascial structures. It is of special interest to physicians performing plastic pelvic surgery.

In a second booth, various members of the Wisconsin Society of Obstetrics and Gynecology will be on duty at specified hours to illustrate and discuss operative obstetrical procedures with demonstrations on the manikin. All types of forcep extractions and rotations with manual maneuvers such as extraction and rotary version will be presented.

BOOTHS 9 AND 10

Cancer of the Breast

Arnold S., James A. and Russell Jackson, Madison

This is an exhibit of moulages and transilluminated colored drawings showing the anatomy of the normal breast. Moulages, roentgenograms and colored photographs depict the diagnosis for carcinoma of the breast. Colored drawings and photographs illustrate the surgical treatment. Moulages and photomicrographs demonstrate the pathology of different types of cancer. Charts show the end results from statistical studies.

BOOTH 11

Applied Medical Art

G. H. Hansmann and Mr. John Stringer, Jr., Milwaukee

Medical illustration has taken a definite place in the field of medicine. It not only instructs and helps the physician in the visualization of gross and microscopic morbid anatomy and the anatomic relationships in the various conditions encountered in the practice of medicine, but it has played a part in the development of understanding between doctor and patient in that the doctor through the medium of illustration may more clearly explain the patient's condition.

Medical illustration is divided into three groups: art, photography and moulage. These three are different types of illustration but are equally important.

Medical art is the paint brush of medicine. Under this heading come all types of drawings such as pencil dust, pen and ink, color, etc. The pencil dust technic is the one that is most often used, because of its life-like qualities and third dimensional effect.

Photography is the medical art that is most frequently used. A photograph is the easiest and cheapest illustration to produce. Medical photography includes clinical, pathologic, operative, photomicrographic movies, etc. All types of medical photography can be done in either black and white or color.

Moulage is the third of the medical arts and the most spectacular. The various parts of the human body and the parts therein can be reproduced and with the aid of oil paints can be made to appear life-like. Under the heading of moulage, but in a field of its own, is the prosthesis. There are many cases in which plastic surgery is of little benefit and a prosthesis is required. Many people are able to return to society and to a normal life with the aid of a prosthesis.

BOOTH 14

Proctoscopic Color Photography

J. M. Garner, Winnetka, Illinois, and J. P. Nesselrod, Evanston, Illinois

These kodochrome transparencies taken through the sigmoidoscope show the appearance of the sigmoid, rectum and anal canal as seen during the routine proctosigmoidoscopic examination.

Views of the normal bowel include the large rugal folds of the sigmoid area, the submucosal vascular network as seen in the walls of the rectum, the rectal valves, the anal papillae and the anal canal.

Pathologic lesions demonstrated include diverticulosis of the sigmoid, chronic ulcerative colitis, tuberculous ulceration, lymphogranuloma venereum, reticulum cell lymphosarcoma, polypoid disease, and adenocarcinoma.

In diverticulosis of the rectosigmoid we usually have a herniation of the mucous membrane through a weakness of the supporting and muscular layers of the bowel wall. These may be innocent and simply filled with fecal plugs, but occasionally an inflammation will develop which starts a train of events that comprise or take part in the pathogenesis of diverticulitis.

The slides on chronic ulcerative colitis illustrate the multiple miliary ulcers with a freely bleeding mucous membrane and an excessive mucoid secretion. During the remissions the scars of these ulcers give a fine granular appearance to the mucosa. Complications of chronic ulcerative colitis include pseudo-polyposis and a stricture of the sigmoid at the site of an ileosigmoidoscopy.

In tuberculous enterocolitis the ulcers are discrete and have elevated margins with dirty, greyish bases.

Lymphogranuloma venereum in the early stages shows rectal stricture with ulceration of the mucous membrane. Later this ulcerated membrane is replaced by scar tissue.

Reticulum cell lymphosarcoma may involve the reticulum cell masses of the submucosa of the bowel giving numerous irregular swellings that are vascular and bleed profusely on the slightest trauma. All normal landmarks can be lost and the lumen of the bowel reduced by one half.

Single polyps before and after fulguration are included as well as congenital multiple polyposis.

Adenocarcinoma involving the sigmoid and rectum is demonstrated.

BOOTH 15

Calcified Nodular Disease of the Aortic Valve

A. H. Wells, S. H. Boyer, Jr., and R. Nelson, St. Luke's Hospital, Duluth, Minnesota

This is an exhibit of thirty-six hearts with this disease. The hearts have been prepared by a gelatin varnished process (Am. J. Clin. Path., Vol. 10, No. 5, May, 1940). These are from a group of 55 cases of the disease found in autopsy studies of 1,250 adults a ratio of 1 to 23. Seventy per cent of these hearts have mitral "rheumatic" lesions and 34 per cent gave a history of rheumatic fever. The symptoms recorded in the histories of the 55 cases are listed in the order of their frequency: dyspnea, decompensation, gastro-intestinal complaints, tightness in chest, cough, palpitation, orthopnea, weakness, cyanosis, hemoptysis, and syncope. Only 44 per cent of these were recognized as being valvular heart disease cases. In about 10 per cent the lesion was designated as aortic valvular disease. Twenty-five per cent had no cardiac symptoms. The average age at death was sixty-one years and the youngest patient was twenty-eight years old. In 73 per cent the aortic lesion seemed to have played an important role in the cause of death. Congestive heart failure occurred in 39 per cent. The heart was enlarged (over 400 grams) in 87 per cent. In 27 per cent the disease appeared to be an incidental finding at necropsy.

What has generally been considered a rare disease is proved to be relatively common in the Duluth region.

BOOTH 16

Wash Wringer Injury

Irwin Schulz, Milwaukee, Surgical Staff, Milwaukee Children's Hospital

The exhibit consists of kodachrome, and black and white transparencies of cases and charts. It depicts the experience of the surgical staff of Milwaukee Children's Hospital in treating 50 patients requiring hospital care and reveals the following:

This injury always involves the upper extremity. There is usually a "point of maximum damage."

The degree of injury may vary from moderate contusion to necrosis and slough of the skin, fat, fascia, nerves, vessels, muscle, and even the bone. The appearance of the arm may be very innocent immediately after injury. The degree and depth of injury are difficult to evaluate at this time. Exudate of blood and plasma into tissues produces further damage. Many patients are admitted ten to fourteen days after injury with a history of having been seen by a physician shortly after injury and the serious consequences not appreciated.

Proper early treatment consisting of cleansing with soap and water and application of a "pressure dressing" prevents progressive destruction and later slough and shortens convalescence. Steps in treatment are outlined.

BOOTHS 17 AND 18

Treatment of Traumatic Injuries of the Face

G. B. New and J. B. Erich, Rochester, Minnesota

The purpose of this exhibit is to present the various surgical procedures which we employ in the treatment of traumatic injuries of the face. The primary and reconstructive care of injuries to the facial bones is demonstrated on wax moulages, consisting of actual casts of skulls and facial models of patients, while colored motion pictures illustrate the treatment of injuries involving both the hard and soft tissues of the face. Shown in detail on models are not only the mechanical and surgical methods of reducing and immobilizing all types of fractures of the mandible, maxilla, malar and nasal bones, but also the technic of grafting bone and cartilage to correct bony facial defects of traumatic origin. In addition, models have been constructed to show our method of obtaining autogenous bone and cartilage grafts for use in plastic operations about the face. This is considered an opportune time to present such an exhibit.

BOOTH 19

Plastic Surgery

V. B. Hyslop, Madison

In this exhibit, motion pictures will be shown on the correction of harelip deformities, cleft palate deformities and Esser's technic of skin grafting. In addition, a study will be shown of the action of the muscles of the soft palate while speaking and swallowing in vivo. The treatment of facial paralysis and other films relative to reconstruction of the face, sterio slides and kodachrome slides of plastic surgery cases before and after operation will also be shown.

BOOTH 20

Prevention of Contagion in Pediatric Wards With the Use of Human Serum or Plasma

L. H. Barenberg, David Greene, Walter Levy and N. M. Greenstein, Morrisania City Hospital, New York, New York

The intramuscular administration of 30 cc. of pooled blood serum or plasma, given routinely on admission to every pediatric case over three months of age, has protected exposed children so inoculated from measles, rubella, scarlet fever, diphtheria, mumps, and chickenpox. Antibodies for these contagious diseases are present in pooled adult plasma or serum and diminish only slightly after prolonged storage.

Since the inception of this method in 1934, the medical pediatric ward has not been quarantined. The complete absence of secondary cases of contagious diseases has also been concomitant with a low incidence of primary cases, suggesting that large amounts of plasma or serum may abort measles and other contagious diseases in the early stage of incubation. Our experience during the last seven years, which included the period of the largest epidemic of measles in the history of New York City in 1940–1941, bears out these contentions.

When a case of primary contagion occurred, all the children who had not received plasma within the previous ten-day period were reinoculated with 30 cc. *Inoculations must be given routinely, even though an epidemic is not in progress.* A constant supply of plasma is made available by utilization of hospital bank blood plasma. Our experience with pooled plasma would suggest that lyophile material could be employed even in the home, because of its convenience and availability.

We advocate the adoption of our procedure by all hospitals, since it has proved effective where isolation alone has failed.

BOOTH 21

Wheezing That is Not Asthma

G. L. Waldbott, Detroit, Michigan

Exhibit of radiographs showing various conditions which (1) were mistakenly diagnosed as asthma; (2) complicated allergic asthma; (3) occurred coincidently with asthma; (4) initiated asthma.

Among the first group are such conditions as moniliasis, substernal goiter, esophageal diverticulum, aortitis, pulmonary abscess, and Pancoast's tumor, etc.

In the second group there are some very unusual complications resulting from bronchial asthma such as cystic disease of lungs, spontaneous pneumothorax, and spontaneous fractures of ribs, chronic atelectasis of a pulmonary lobe.

In the third group there is a case of dextrocardia, of saccular bronchiectasis of one lung causing practically no symptoms, tuberculosis coincident with asthma.

Among conditions which initiated asthma of long standing are Loeffler's syndrome, pneumonitis, and allergic shock.

BOOTH 22

Fenestration Operation For the Improvement in Hearing in Otosclerosis

George Shambaugh, Jr., Chicago

Otosclerosis is the most frequent and important cause for progressive hearing impairment in early and middle adult life. The fenestration operation for the first time offers the possibility of a partial restoration of the hearing loss in persons deafened by otosclerosis.

The exhibit is based on a four-year experience with the fenestration operation. The fenestration operation is described historically, theoretically and technically, with a series of anatomic specimens illustrating the steps in the surgical technic. On the right side wall the complete results in a series of more than 200 operations over the last four years will be presented in detail. These results show that:

1. A hearing improvement maintained for more than six months after the fenestration operation may be regarded as probably permanent.
2. The technic now being used gives a probably permanent hearing improvement in 90 per cent of properly selected cases.
3. The fenestration operation is not always successful and the hearing may be made worse in the operated ear (1.5 per cent of cases). For this reason the poorer hearing ear should always be selected for operation.
4. There has been no fatality, early or late, and no serious complication in this series.
5. The success of the present technic depends upon the careful selection of cases, the maintenance of scrupulous asepsis during the operation and the postoperative care, the strict adherence to a meticulous technic under adequate magnification, the use of an irrigating device to wash away every particle of bone dust during the creation of the labyrinthine window or fenestra, and the covering of the fenestra with an intact viable plastic skin flap free from bone chips and continuous with the drum membrane.

BOOTH 23

Bronchoscopy and Esophagoscopy For Removal of Foreign Bodies and the Treatment of Diseases of Air and Food Passages

Wellwood Nesbit, Madison

The exhibit will include the specula used in the inspection of the air and food passages. The technic of removing foreign bodies and new growths from these passages will be illustrated.

It will also include methods of introducing therapeutic agents directly into the bronchi for infections in this area.

Slides made from roentgenograms of the chest will show foreign bodies as well as other pathological lesions in the author's series of cases.

BOOTH 24

Appendicitis in Rock County

Rock County Medical Society

The Rock County Medical Society is attempting a survey of the various branches of its medical work and one of the subjects selected was appendicitis.

It has been stated that the high mortality on appendicitis is due to the inexperienced country doctor considering an appendectomy a simple operation and attempting the operative proceedings himself. In order to prove or disprove this statement an attempt has been made to study this problem in Rock County. We have taken all the histories of appendicitis that have been operated upon in Mercy Hospital since it was taken over by the Sisters of Mercy in July, 1907, up to January 1, 1942. Taken into this survey are appendectomies which have been done not of necessity, but because the appendix was easily removed at the time of some abdominal operation.

In many of the early cases there are no clear cut histories of the cases nor good pathological reports, but since about 1922 the histories are quite clear.

In the Beloit Hospital, which is a Municipal Hospital with an open staff, we have made a survey of all the cases since the hospital started in 1929 up to January 1, 1942. The records of earlier cases done in various Beloit hospitals, before the present hospital, have been lost or destroyed. In the Edgerton Hospital, which is a soldiers' memorial hospital, there are no records that give us any data on the cases available earlier than 1928, although the hospital was started in 1913. From 1928 to January 1, 1942, we have been able to make a brief survey upon these cases.

Some of the things which we have tried to bring out were the instances of rupture after giving cathartics, the operative procedure after general peritonitis had been established from rupture, and also a series of cases after the induction of the sulfa drugs in acute appendicitis.

We have tried to tabulate the results as to age incidents, seasonal onsets, and so forth. It makes a very interesting survey of Rock County, which has a population of about 70,000, including Beloit, 30,000, Edgerton, 3,000, and Janesville, 23,000, and we present it with the idea of getting more county medical societies interested so that they perhaps will make similar surveys.

BOOTH 25

Food For Fitness

State Medical Society of Wisconsin

An exhibit emphasizing the importance of the inclusion of dairy products in the everyday diet will be shown in the scientific exhibit section. Nutritional facts concerning cheese, butter, milk and meat will be outlined. Slides portraying the importance of dairy products in nutrition will be projected continuously in the booth. Extra copies of the supplement to the June issue of *The Wisconsin Medical Journal*, in which were reprinted articles on nutrition appearing in earlier issues of *The Journal*, will be available.

BOOTHS 26 AND 27

Treatment of Rheumatoid Arthritis

Wisconsin Rheumatism Association

In the last two years differential diagnosis as a fundamental need before treatment, and the use of physical therapy have been presented in this booth. This year the technic of rest to preserve structure and function will be illustrated in the booth by patients, demonstrators, and physicians.

BOOTH 28

Anatomy of the Heart

Walter Zeit, Ph. D., Milwaukee

This exhibit will consist of dissected specimens of the human heart revealing the chambers of the heart and other gross anatomic features. A series of injected specimens will be demonstrated to show the blood supply and circulation through the heart wall. The exhibit will be augmented by explanatory charts.

BOOTHS A, 31, 32 AND 33

Applied Anatomy

Walter Zeit, Ph. D., Marquette University School of Medicine, Milwaukee, W. E. Sullivan, Ph. D., University of Wisconsin, Madison

Dissections will be demonstrated showing the anatomy of the pelvic floor and female reproductive system, the male perineum and relations of the prostate, the inguinal canal and associated structures. In addition, a superficial dissection of the back and a dissection of the structures related to the posterior abdominal wall will be demonstrated.

As in the last years this demonstration is offered to acquaint the physicians of the state with the fact

that they have access to anatomical material. There will be dissections of the neck and hand prepared by Dr. Otto Hibma.

BOOTH 34

Central Nervous System Factors in Fatigue and Disease

Norbert Enzer, Samuel Blankstein and Ernst Simonson, Mount Sinai Hospital, Milwaukee

This is an exhibit showing that because the fusion frequency of flicker is a fundamental visual function and is an indicator of the excitability of visual centers, it was used to study some of the central nervous system factors in fatigue and general disease. Charts show that the fusion is diminished in normal fatigue of the central nervous system. Patients with cardiac disorders and hypothyroidism were found to have depressions of the fusion. The fusion was found to rise as fatigue was relieved. Amphetamine, desoxyephedrine, vitamin B complex surplus raised the fusion in normal states. Methylestosterone achieved the same results in hypogonadism. Charts demonstrate fatigue of the motor centers in normal states and in disease and the effect of amphetamine and desoxyephedrine.

BOOTH 35

Experimental Ameboid Motion of Motor Nerve Plates

Eben J. Carey and Mr. Leo C. Massopust, Marquette University School of Medicine, Milwaukee

This is an exhibit of specimens, charts and photomicrographs showing that the pleomorphism of the motor nerve plates and muscle striations are experimentally related to physiologic and pathologic functions. By excitation and depression of the nervous system there is demonstrated a correlation between the morphologic structure and the capillary chemistry of muscle and nerve. Periodic bands analogous to cross striations in muscle are experimentally produced by capillary chemical activity in glass tubes. The morphologic evidence of periodic expansion and retraction of motor nerve plates in striped muscle supports the chemical theory for the transmission of the impulse from nerve endings to muscle. Acute starvation results in "inanition block" of nerve impulse with great expansion of axones outside of muscle fiber and retraction and uprooting of nerve branches in motor end plate.

BOOTH B

The Use and Abuse of Barbiturates

American Medical Association, Chicago

This exhibit from the Council on Pharmacy and Chemistry of the American Medical Association shows that there are more than 1,200 possible homologues of barbital, of which about thirty are on the market. The barbiturates are used to secure a quieting effect, to suppress convulsions and to produce anesthesia. There is a slight lowering of temperature, a fall in blood pressure when administered too rapidly, and a slowing of respiration. The barbiturates produce a prompt and dreamless sleep and large single doses really produce disturbances or serious local irritation. In some instances, however, the response is variable and the hypnotic effect is followed by excitement and delirium; skin reactions may be produced by susceptible persons.

Addiction from repeated doses is fairly easily acquired in some individuals, reducing the hypnotic effect and leading to chronic poisoning, mental upsets and digestive disturbances. Suicides by the use of barbiturates have been increasing over the years, but many states now have restricted the sale of the drug to prescriptions by physicians.

BOOTH C

Educational Literature

Wisconsin State Board of Health

In this exhibit samples of educational material that are available for distribution by the various divisions of the Wisconsin State Board of Health will be displayed. The complete list of all publications, film strips and educational films will be available. Representatives will be glad to discuss public health problems with any individual physician.

BOOTHS P, Q AND R

Automobile Drivers Clinic

Motor Vehicle Department, Madison

For the last few years the Safety Division of the Motor Vehicle Department has provided an educational and scientific exhibit at the meetings of the State Medical Society of Wisconsin that has always been popular with those in attendance.

A great many of our highway traffic accidents are due to lack of knowledge of our individual conditions. Most of us think we are excellent drivers, but few of us realize our limits of judgment, vision and ability to act quickly in emergency. The tests provided by the driver clinic are for the specific purpose of acquainting the motorist with his ability as a driver, and upon completion of the test, which requires but a few minutes, an accurate analysis can be made of the results, which is most enlightening.

The driver clinic is an educational and promotional idea and the results of the tests do not affect one's driver's license. The tests include visual acuity, color blindness, depth perception, muscular imbalance, fusion, brake reaction time, glare reaction, steering reaction and knowledge of Wisconsin traffic laws.

Approximately 15,000 persons are tested annually in Wisconsin by the Safety Division's driver clinic. It is booked to appear at several state-wide conventions this year in addition to the state fair, numerous county fairs and several schools.

Technical Exhibitors at One Hundred First Anniversary Meeting

A. S. Aloe Company, St. Louis, Missouri
Borden Company, New York, New York
Camel Cigarettes, New York, New York
S. H. Camp and Company, Jackson, Michigan
Carnation Company, Oconomowoc
Conformal Footwear Company, St. Louis, Missouri
R. B. Davis Sales Company, Hoboken, New Jersey
DePuy Manufacturing Company, Warsaw, Indiana
H. G. Fischer and Company, Chicago, Illinois
General Electric X-ray Corporation, Milwaukee
Gerber Products Company, Fremont, Michigan
Chr. Hansen's Laboratory, Inc., Little Falls, New York
H. J. Heinz Company, Pittsburgh, Pennsylvania
Horlick's Malted Milk Corporation, Racine
Hurley X-ray Company, Milwaukee
Mead Johnson and Company, Evansville, Indiana
E. H. Karrer Company, Milwaukee
Kellogg Company, Battle Creek, Michigan
Kremers–Urban Company, Milwaukee
Lakeside Laboratories, Inc., Milwaukee
Eli Lilly and Company, Indianapolis, Indiana
J. B. Lippincott Company, Philadelphia, Pennsylvania
Medical Protective Company, Fort Wayne, Indiana
Medico-Mart, Inc., Milwaukee
Mellin's Food Company, Boston, Massachusetts
Mennen Company, Newark, New Jersey
Merck and Company, Inc., Rahway, New Jersey
C. V. Mosby Company, St. Louis, Missouri
V. Mueller and Company, Chicago, Illinois
Parke, Davis and Company, Detroit, Michigan
Pet Milk Sales Corporation, St. Louis, Missouri
Petrogalar Laboratories, Inc., Chicago, Illinois
Philip Morris and Company, Ltd., New York, New York
Photoart House, Milwaukee
Physicians and Hospitals Supply Company, Inc., Minneapolis, Minnesota
Roemer Drug Company, Milwaukee
W. B. Saunders Company, Philadelphia, Pennsylvania
Scanlan–Morris Company, Madison
Schering Corporation, Bloomfield, New Jersey
G. D. Searle and Company, Chicago, Illinois
Sharp and Dohme, Inc., Philadelphia, Pennsylvania
Smith, Kline and French Laboratories, Philadelphia, Pennsylvania
E. R. Squibb and Sons, New York, New York
U. S. Hospital Supply Company, Minneapolis, Minnesota
Westinghouse X-ray Company, Milwaukee
White Laboratories, Inc., Newark, New Jersey
Winthrop Chemical Company, Inc., New York, New York
John Wyeth and Brother, Inc., Philadelphia, Pennsylvania

NO REGISTRATION FEE

Because of the revenue received from the technical exhibitors for exhibit space, it is possible for you to attend the One Hundred First Anniversary Meeting without paying a registration fee. If it were not for this revenue, the per capita cost for physicians attending the meeting would be from $4 to $5.

These firms have a genuine message for you; both the exhibitors and you will be repaid many times if you stop at their booths.

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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New Members and Old—Welcome!

WELCOME to Milwaukee for the annual meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin!

When we began our organization fourteen years ago, our ideals were earnest and sincere but withal a bit sentimental in what we, as a lay organization, could do in the cause of better medicine. In the year 1942 with our country at war, we find ourselves in the position of a lay organization that must have real impact and importance in our various communities in the effort that we are called upon to put forth for our country, which is so seriously engaged.

It is earnestly hoped that every doctor's wife, whether she be a member of the Auxiliary or not, has put the dates September 13, 14 and 15 on her calendar that she may then become familiar with the splendid work that has been accomplished in the months recently passed and may share the privilege of helping in the organization of the work that lies ahead.

The Milwaukee County Auxiliary, with the assistance of the Kenosha and Walworth County Auxiliaries, has planned a delightful two-day session for us, and a record attendance of enthusiastic members and friends will assure our hostesses of our pleasure in their gracious hospitality.

One of the high lights of the convention will be the talk by Susan Burdick Davis, former assistant dean of women at the University of Wisconsin, who will speak to us at our Tuesday luncheon on the subject of "Everyday Life in Wisconsin in 1848." Miss Davis, who received her master's degree from Northwestern University and an honorary doctorate from Milton College, is one of the outstanding historians of our state

Mrs. J. S. Supernaw, Madison
President

and has made a valuable contribution to Wisconsin literature through her books and plays of the folklore of our people. This summer she has been engaged in the study of early medicine and the contributions made to it by Dr. Beaumont in his work in the Green Bay area. We are fortunate in this opportunity to hear from one so well equipped to speak to us on our heritage.

Let each one of us put aside our routine affairs and assemble in Milwaukee for a renewal of friendships and a stimulating exchange of pleasures and problems.

HELEN M. SUPERNAW
President

PROGRAM

Sunday, September 13, 1942

P. M.

2:00–4:30 Registration—Hotel Schroeder

7:00 Board of Directors' Dinner—Hotel Schroeder
Mrs. J. S. Supernaw, president, presiding
Guests
Past-presidents, Woman's Auxiliary to the State Medical Society of Wisconsin
Wisconsin's three national officers: Mrs. Eben J. Carey, Wauwatosa, president-elect; Mrs. Robert E. Fitzgerald, Wauwatosa, parliamentarian; Mrs. George H. Ewell, Madison, editor of the Bulletin, press and publicity chairman

Monday, September 14, 1942

A. M.

10:00 General Meeting—Club Rooms, Hotel Schroeder
Mrs. J. S. Supernaw, president, presiding
Invocation—Paul Wagner Roth, D. D., Church of the Epiphany, Milwaukee
Convention Anouncements
Address of Welcome—Mrs. Harry O. Zurheide, president, Woman's Auxiliary to the Medical Society of Milwaukee County
Response—Mrs. E. D. Sorenson, president, Woman's Auxiliary to the Walworth County Medical Society
In Memoriam
Convention Rules and Procedure — Mrs. W. E. Sullivan, parliamentarian
Minutes of Annual Meeting, 1941
Reports of State Officers
Reports of County Auxiliary Presidents
Report of Chairman, Committee on Credentials and Registration
Announcements

Mrs. E. S. Schmidt, Green Bay
President-elect

P. M.

1:00 Luncheon and Bridge—Banquet Room, Hotel Schroeder
Hostesses—Members of the Woman's Auxiliary to the Walworth County Medical Society
Style Show—Fashions by Hixon's
Tickets—$1.35

7:00 Buffet Supper—Banquet Room, Hotel Schroeder (Courtesy, State Medical Society of Wisconsin)
Entertainment—Lucille La Chapelle
Music—Schubert Ensemble

Tuesday, September 15, 1942

A. M.

10:00 General Meeting — Club Rooms, Hotel Schroeder
Mrs. J. S. Supernaw, president, presiding
Business Session
Election of Officers
Induction of the President, Mrs. Ernest S. Schmidt
Installation of New Officers
Announcements
Report of Committee on Credentials and Registration

11:30 Post-Convention Meeting—Board of Directors —Club Rooms, Hotel Schroeder
Mrs. Ernest S. Schmidt, president, presiding

P. M.

1:00 Luncheon — Cudworth Post of American Legion

Hostesses—Members of the Woman's Auxiliary to the Kenosha County Medical Society

Greetings from Dr. Gunnar Gundersen, president, State Medical Society of Wisconsin

Round-table Discussions of Auxiliary Activities

Presidents—Mrs. E. S. Schmidt, Green Bay
Treasurers—Mrs. E. P. Bickler, Milwaukee
Archives—Mrs. J. P. Connell, Fond du Lac
Finance—Mrs. R. E. Fitzgerald, Wauwatosa
Hygeia—Mrs. A. C. Taylor, Appleton
Organization—Mrs. O. W. Friske, Beloit
Philanthropic — Mrs. J. W. MacGregor, Portage
Program—Mrs. C. N. Neupert, Madison
Press and Publicity—Mrs. F. W. Aplin, Waukesha
Public Relations—Mrs. D. H. Jeffers, Lake Geneva
Circulation of Bulletin—Mrs. Charles Fidler, Milwaukee
Legislation—Mrs. H. K. Tenney, Madison

Address—"Everyday Life in Wisconsin in 1848"—Miss Susan Burdick Davis, former dean of women, University of Wisconsin

Tickets—$1.35

6:45 Informal Banquet, State Medical Society of Wisconsin —Crystal Ballroom, Hotel Schroeder

"The Doctor's Part in the War Program"—Fred W. Rankin, president, American Medical Association

Annual Meeting Committees*

Executive Committee

Mrs. R. D. Champney, chairman
Mrs. E. M. Lawler, Cudahy, co-chairman
Mrs. P. A. Lee, co-chairman

Headquarters–Reception

Mrs. C. D. Partridge, Cudahy, chairman
Mrs. F. R. Janney, Wauwatosa, co-chairman

Hostesses

Officers and Members of the Board of Directors of the Woman's Auxiliary to the Medical Society of Milwaukee County
Mrs. H. O. Zurheide, president
Mrs. F. R. Janney, Wauwatosa, president-elect
Mrs. R. H. Frederick, West Allis, vice-president
Mrs. E. J. Behnke, Wauwatosa, recording secretary
Mrs. D. E. W. Wenstrand, corresponding secretary
Mrs. J. L. Kinsey, treasurer
Mrs. R. E. Fitzgerald, Wauwatosa, parliamentarian
Mrs. E. F. Barta, director
Mrs. T. H. Rolfs, director
Mrs. W. A. Ryan, director
Mrs. T. S. O'Malley, director
Mrs. I. Schulz, Wauwatosa, director
Mrs. S. J. Silbar, director

Registration and Credentials

Mrs. E. J. Schelble, chairman
Mrs. R. P. Schowalter, Wauwatosa, co-chairman
Mrs. D. H. Witte
Mrs. Irwin Schulz, Wauwatosa

Reservations

Mrs. G. J. Pugh, chairman
Mrs. R. C. Pfeil, co-chairman
Mrs. H. F. Farrell
Mrs. R. P. Gingrass, Wauwatosa
Mrs. R. E. Stockinger, Wauwatosa

Publicity

Mrs. E. M. Lawler, Cudahy, chairman
Mrs. R. E. Fitzgerald, Wauwatosa, co-chairman

* Unless otherwise indicated, committee members are from Milwaukee.

Convention Hall—Pages

Mrs. E. L. Everts, Wauwatosa, chairman
Mrs. R. H. Frederick, West Allis, co-chairman
Mrs. N. W. Bourne
Mrs. F. C. Heidner
Mrs. F. A. Kretlow
Mrs. W. P. O'Malley, Wauwatosa

Information

Mrs. W. F. Grotjan, chairman
Mrs. G. H. Friedman, co-chairman
Mrs. J. J. Adamkiewicz
Mrs. E. F. Barta
Mrs. B. P. Churchill
Mrs. P. M. Currer
Mrs. G. J. Gumerman
Mrs. F. J. Gaenslen
Mrs. J. T. Klein
Mrs. H. S. Smith, Cudahy
Mrs. L. B. Uszler

Program

Mrs. P. A. Lee

Flowers

Mrs. V. L. Baker, chairman
Mrs. D. E. W. Wenstrand, co-chairman
Mrs. E. J. Behnke, Wauwatosa
Mrs. D. D. Frawley
Mrs. J. L. Kruszewski
Mrs. G. E. Thill, Wauwatosa

Monday Luncheon

Mrs. W. M. Jermain, chairman
Mrs. E. F. Barta
Mrs. J. J. Gramling, Jr.

Monday Luncheon Hostesses—Walworth Auxiliary

Mrs. E. D. Sorenson, Elkhorn, chairman
Mrs. J. A. Rawlins, Elkhorn
Mrs. T. L. Jacobson, Delavan
Mrs. H. J. Kenney, Delavan
Mrs. F. L. O'Keefe, Delavan
Mrs. D. H. Jeffers, Lake Geneva
Mrs. J. D. Warrick, Sharon
Mrs. R. C. Halsey, Lake Geneva
Mrs. T. J. Kroyer, Walworth
Mrs. S. G. Meany, East Troy
Mrs. L. Keenan

Monday Evening—Buffet Supper

Mrs. T. M. Northey, chairman
Mrs. E. L. Bernhart, co-chairman
Mrs. M. A. Bussewitz
Mrs. C. E. Bellehumeur
Mrs. E. P. Bickler
Mrs. H. A. Cunningham, Shorewood
Mrs. Charles Fidler
Mrs. U. E. Gebhard
Mrs. H. J. Heeb
Mrs. H. J. Cannon
Mrs. J. D. Owen
Mrs. A. R. F. Grob
Mrs. T. H. Rolfs
Mrs. C. R. Eichenberger
Mrs. R. T. Gilchrist
Mrs. G. J. Pugh
Mrs. P. J. Purtell
Mrs. R. P. Gingrass, Wauwatosa
Mrs. Ervin Hansher
Mrs. E. J. Carey, Wauwatosa

Tuesday Luncheon

Mrs. W. C. Liefert, chairman
Mrs. A. R. Langjahr

Tuesday Luncheon Hostesses—Kenosha Auxiliary

Mrs. Edgar Andre, Kenosha, chairman
Mrs. C. F. Ulrich, Kenosha
Mrs. A. L. Mayfield, Kenosha
Mrs. C. M. Creswell, Kenosha

Mrs. R. D. Champney, Milwaukee
Convention Chairman

Delegates and Alternate Delegates to the Fourteenth Annual Meeting of Woman's Auxiliary to the State Medical Society of Wisconsin

County	*Delegate*	*Alternate*
Brown–Kewaunee–Door	Mrs. George Goggins	Mrs. I. E. Levitas
	Mrs. M. H. Fuller	Mrs. E. S. McNevins
Columbia–Marquette–Adams	Mrs. J. P. Harkins	Mrs. J. H. Houghton
	Mrs. J. W. MacGregor	Mrs. R. B. Dryer
Dane	Mrs. W. A. Werrell	Mrs. Lindley Sprague
	Mrs. T. W. Tormey, Jr.	Mrs. B. I. Brindley
Fond du Lac	Mrs. F. M. McGauley	Mrs. E. V. Smith, Jr.
	Mrs. H. E. Twohig	Mrs. A. M. Hutter
Kenosha	Mrs. Leif H. Lokvam	Mrs. J. P. Graves
	Mrs. A. M. Rauch	Mrs. Theodore Sokow
La Crosse	Mrs. Frederick H. Wolf	
	Mrs. James C. Fox	
	Mrs. F. A. Douglas	
Manitowoc	Mrs. E. C. Cary	Mrs. Nathan Schneck
	Mrs. Thomas H. Rees	Mrs. R. W. Hammond
Marinette–Florence	Mrs. J. V. May	
	Mrs. H. L. Jorgenson	
Milwaukee	Mrs. G. H. Hoffman	Mrs. F. D. Murphy
	Mrs. O. A. Lotz	Mrs. D. D. Frawley
	Mrs. J. J. Adamkiewicz	Mrs. T. S. O'Malley
	Mrs. F. R. Janney	Mrs. I. Schulz
	Mrs. J. Lettenberger	Mrs. S. J. Silbar
	Mrs. F. J. Kozina	Mrs. E. F. Barta
	Mrs. R. W. Blumenthal	Mrs. D. E. W. Wenstrand
	Mrs. C. C. Schneider	Mrs. E. J. Behnke
Outagamie	Mrs. R. T. McCarty	Mrs. E. J. Zeiss
	Mrs. Guy W. Carlson	Mrs. D. W. Curtin
Racine	Mrs. R. D. Jamieson	Mrs. H. B. Keland
	Mrs. R. M. Kurten	Mrs. H. G. Brehm
	Mrs. G. A. Dockery	
	Mrs. R. S. Wright	
Rock	Mrs. C. R. Gilbertsen	Mrs. G. W. John
	Mrs. H. E. Kasten	Mrs. R. C. Hartman
Sheboygan	Mrs. H. J. Hansen	Mrs. J. W. McRoberts
	Mrs. G. J. Hildebrand	Mrs. E. T. Hougen
Walworth	Mrs. E. D. Sorenson	Mrs. S. G. Meany
	Mrs. T. J. Kroyer	Mrs. T. L. Jacobson
Washington–Ozaukee	Mrs. M. E. Monroe	Mrs. J. E. Reichert
Waukesha	Mrs. T. H. Nammacher	Mrs. E. Lee Lochen
	Mrs. K. W. Doege	Mrs. J. F. Wilkinson
Waupaca–Shawano	Mrs. W. J. Irvine	Mrs. L. G. Patterson
	Mrs. E. A. Miller	Mrs. J. W. Monsted

County Auxiliary Proceedings

Racine

Twenty members of the Woman's Auxiliary to the Racine County Medical Society met at the home of Dr. and Mrs. Francis A. Malone, Waterford, on June 29. Refreshments were served in the garden, with Mrs. Richard J. Dietz of Waterford and Mrs. Lester O. Mastalir of Burlington as co-hostesses. Bridge was played during the afternoon.

Sauk

Mrs. Harold A. Bachhuber, Sauk City, was announced as president of the Woman's Auxiliary to the Sauk County Medical Society at the final spring meeting held on June 18 at the home of Dr. and Mrs. Carl B. Pope, Baraboo.

Other officers are the president-elect, Mrs. A. T. Johnson, and secretary-treasurer, Mrs. Thomas W. Walsh, both of Sauk City.

Walworth

Members of the Woman's Auxiliary to the Walworth County Medical Society met for a one o'clock luncheon at the Sterlingworth Hotel at Lauderdale Lake for their July meeting.

An interesting paper on "The Declining Family in America" was read by Mrs. Joseph A. Rawlins of Elkhorn. Delegates to the fourteenth annual session of the Auxiliary were named.

The members of this society will be co-hostesses with those of the Milwaukee County Auxiliary and the Kenosha County Auxiliary at the annual convention.

Annual Reports of the Officers and Committees to the 1942 House of Delegates

1. REPORT OF THE COUNCIL

Minutes of all Council meetings held since September, 1941, have been published in *The Wisconsin Medical Journal.* These Journals are available to all members, and no effort has been made to summarize the various activities undertaken by the Council since the September, 1941, meeting of the House of Delegates. However, pursuant to custom, the chairman of the Council will amplify the printed report when the House is in session.

The Council reports as a whole a satisfactory status of the State Medical Society in the administration of the affairs with which it was charged during the interim since the last session of the House of Delegates. The war and the many complexities in professional and civilian life, arising from the fact that this nation is so involved, have thrown an unusual strain and stress upon the structure of the State Medical Society. Despite these unusual circumstances the Council is able to report that every essential activity of the Society is being maintained at its normal complement during this period of national emergency. The Council is satisfied that in the discharge of the responsibility of the State Medical Society of Wisconsin to the general field of public health, the position of the Society continues to be favorable.

One of the more difficult problems of the Society has been the integration of its responsibilities to national emergency activities as a whole. Of the more important is that concerned with the development of the Procurement and Assignment Service, as well as that concerning the medical profession's participation in civilian defense activities.

Some time ago the Council created the M-Day Committee originally composed of Drs. R. E. Fitzgerald, chairman, and R. W. Blumenthal and J. L. Lambert. At the January Council meeting, Dr. C. N. Neupert, assistant state health officer, was added to the personnel of that committee. The committee members have worked hard and long in the discharge of their responsibilities, both as representatives of the medical profession in Wisconsin and in the quasi-public positions held by them. In July, it became obvious that the complexities of the responsibilities of the profession in the war demanded the complete reorganization of this endeavor. Consequently, as announced in the August *Journal*, the Committee on War Participation of the State Medical Society of Wisconsin was organized with the following appointments being made by the chairman of the Council:

Committee on War Participation

President; president-elect; chairman of the Council; state consultant of Procurement and Assignment Service; secretary, ex officio.

Subcommittee on Procurement and Assignment Service

E. J. Carey, Milwaukee, chairman
H. M. Coon, Madison
J. W. Prentice, Ashland
F. X. Pomainville, Wisconsin Rapids
P. R. Minahan, Green Bay

Subcommittee on Replacements

R. W. Blumenthal, Milwaukee, chairman
S. D. Beebe, Sparta
E. C. Cary, Reedsville
H. A. Sincock, Superior
A. A. Cantwell, Shawano

Subcommittee on Civilian Defense

J. W. Lambert, Antigo, chairman
R. W. Blumenthal, Milwaukee
J. S. Supernaw, Madison
V. E. Ekblad, Superior
T. C. Hemmingsen, Racine
A. G. Koehler, Oshkosh
F. G. Anderson, Eau Claire
C. N. Neupert, Madison

The Council conceives these responsibilities to be those of the profession in Wisconsin as a whole, and in a larger sense, part of the problems of the lay citizenry as well.

In the field of Procurement and Assignment, Dr. R. E. Fitzgerald, state consultant, is charged with an ultimate responsibility which it would be impossible for him to discharge were it not for a cooperative attitude on the part of all physicians. Officers of the Procurement and Assignment Service act as officials of the government; the responsibility assigned to them was at the insistence of the medical profession which proclaimed its complete and successful cooperation. The Council of the State Medical Society so views the problem: in the manifold ways in which the privilege is that of the medical profession of the State of Wisconsin, that cooperation will be forthcoming from the entire profession.

Civilian defense presents another aspect, the importance of which may be readily underestimated in the multitude of problems confronted. In that, as in Procurement and Assignment, the Council views the problem as one of state-wide significance, and the

facilities of the profession have been extended to civilian defense authorities as they may best be used.

The Council submits this report to the members in the full conviction that these policies are basic to the success of the profession in properly discharging its wartime responsibilities. At the same time, emphasis on these activities should not be so placed as to give the impression that other matters of basic importance to public health are being laid aside for the duration. Such is not the case. The Council notes the success with which the graduate centers held this last spring were conducted; various responsible committees of the Society continue to function without substantial disruption; and the major work of the Society continues, although constantly readjusted to permit absorption of wartime activities.

Amendment to the Constitution

At the 1941 session of the House of Delegates the Council recommended that the Constitution be amended by striking from Article II the phrase reading "to guard and foster the material interests of its members and to protect them against imposition."

The Council calls to the attention of the delegates that this proposal having been printed on two separate occasions will come before the delegates at the 1942 meeting.

It is suggested that the amendment should be accepted by the delegates because the clause concerned conveys an erroneous impression of the Society's responsibilities.

Report on Necrology

The Council has the sad duty of reporting the deaths of the following physicians since the last anniversary meeting. Members of the Society are indicated by boldface type.

Barnstein, J. E. ____ Manitowoc
Beebe, C. D. ____ Sparta
Bird, M. D. ____ Marinette
Boerner, R. W. ____ Milwaukee
Carter, R. M. ____ Green Bay
Chandler, Joseph ____ Pardeeville
Collins, W. P. ____ Racine
Darling, W. S. ____ Milwaukee
Davis, K. W. ____ Green Bay
De Voe, C. A. ____ Berlin
Dillman, A. E. ____ Steuben
Dorpat, Louis ____ Milwaukee
Drozniakiewicz, L. F. ____ Milwaukee
Dwyer, J. E. ____ Milwaukee
Goldenberg, M. D. ____ Milwaukee
Griswold, C. M. ____ Milwaukee
Hagerman, F. H. ____ Milwaukee
Helz, J. W. ____ Fond du Lac
Hewson, W. J. ____ Alma Center
Hornig, J. P. ____ Cedarburg
Hubenthal, J. C. ____ Belmont
Hughes, J. R. ____ Milwaukee
Karass, H. D. ____ Milwaukee
Krohn, H. C. ____ New Holstein
Lemmel, J. T. ____ Beloit
Loope, T. E. ____ Iola
Marsh, J. M. ____ Elkhorn
Mast, B. W. ____ La Crosse
Mathes, George ____ Kiel
Maurer, A. A. ____ New York
McNaughton, W. T. ____ Milwaukee
Morter, C. W. ____ Milwaukee
Nolte, L. G. ____ Milwaukee
Pfeifer, H. A. ____ Milwaukee
Pfister, Franz ____ Milwaukee
Reinhard, H. A. ____ Milwaukee
Richardson, Louis ____ Jump River
Rogers, R. B. ____ Neenah
Rothberg, B. J. ____ Hayward
Ryan, E. R. ____ Milwaukee
Sandin, N. V. ____ Ashland
Sattre, O. M. ____ Rice Lake
Schneider, Hans ____ Dousman
Schmitt, Philip ____ Milwaukee
Schroeder, E. L. ____ Shawano
Sisk, J. N. ____ Madison
Sleyster, Rock ____ Wauwatosa
Stack, S. S. ____ Milwaukee
Steinberg, H. S. ____ Milwaukee
Stiehm, R. H. ____ Madison
Stirn, F. J. ____ Milwaukee
Stoddard, C. H. ____ Milwaukee
Suhr, A. L. ____ Milwaukee
Taylor, A. R. ____ Brodhead
Tennies, H. B. ____ Allouez
Thompson, F. A. ____ Milwaukee
Tormey, T. W. ____ Madison
Walch, F. C. ____ Clintonville
Wallschlaeger, G. G. ____ Milwaukee
Williams, A. J. ____ Racine
Wing, W. S. ____ Oconomowoc
Wittke, A. R. ____ Milwaukee
Zierath, W. F. ____ Sheboygan

2. REPORT OF THE SECRETARY

Membership

As of August 15, 1942, the active membership totaled 2,537, which is summarized as follows:

1. Fully paid members ____ 2,198
2. Partially paid members ____ 42
3. Members in military service who paid no dues in 1941 and 1942 ____ 105
4. Members in military service who paid prorata dues in 1942 ____ 76
5. Members recently reported in service on whom correspondence is pending ____ 54
6. Life members, honorary members, members whose dues were waived because of temporary but serious incapacity ____ 62

It is estimated that the active membership this year will approximate 2,600.

Office Effort

While a large volume of the work of your Society's office is reflected in the current reports of the various committees that follow, there is always much of an individual character developed throughout the year. A considerable amount of organization and routine work is necessary in discharging the Society's functions, and little of this is readily apparent to the members. Your secretary expresses again the hope that any member who happens to be in Madison will pay the office a visit. It is a welcomed opportunity to chat informally with the members and to explain to them the various procedures which have been followed over a period of years.

One employe of the office is required to devote her full time to the maintenance of the Society's membership records, mailing membership certificates and cards, and the other routines attendant on the involved procedure necessary to account correctly for the many members of the Society. The editing of the monthly publication, and the preparation of much of the material for it, occupies the attention of still another employe, while two employes are necessary for the secretarial work involved in handling the dictation of the secretary and the assistant secretary. Hayden Smith, an employe of the Society for the last several years, is currently assigned to the work of the Committee on Public Policy, as well as particular functions in various studies being constantly undertaken, the reporting of committee and conference meetings, and similar work.

The normal outgoing mail of the Society, first class, has averaged something over fifty pieces a day during the last several years—with wartime activities added, this has nearly doubled. Consequently, the services of part-time or full-time secretaries are occasionally demanded, and if the emergency continues to impose additional demands upon the organization of medicine, still another full-time assistant is necessary.

Your secretary expresses his appreciation for the many courtesies extended him during his first endeavors in that office. Members have never failed to be cooperative far beyond what the circumstances indicated, and the office staff has supported the work of the Society with a truly amazing degree of loyalty and hard work. Positions in other fields have offered two of our employes better financial opportunities, while another will accompany her husband to those posts to which he may be assigned as a result of voluntary enlistment in the service. Replacements have been obtained which will assure a continuance of the high caliber of work that has characterized all the Society's employes. The one comment which must be made in conclusion is your secretary's belief that in the State Medical Society of Wisconsin is found a remarkable example of a well knit, completely cooperative organization in which the many physicians called upon never hesitate to serve. It is an organization which is truly an example of the selfless character of the physician, and a tribute to that individual who knew only the honest goal for the future.

3. REPORTS OF STANDING COMMITTEES

COMMITTEE ON CANCER

Charles Fidler, chairman, L. J. Van Hecke, A. L. Mayfield, C. F. Dull, J. C. Fox, W. S. Bump, Julius Blom, E. E. Evenson, J. W. McGill, E. F. Schneiders, T. A. Teitgen, Erich Wisiol, G. E. Eck, D. J. Twohig

The activities of the Committee on Cancer during the last year can be divided roughly into two categories. First, consideration of scientific postgraduate work and second, advising the Women's Field Army in their lay education efforts.

The committee has taken initial steps to revive the intensive postgraduate medical efforts that were originally developed by this committee some years ago. The recommendation was made to the Women's Field Army in 1941 that there be made available to the Council on Scientific Work of the State Society a sum sufficient to assist that Council in the continuance of postgraduate medical education in cancer at the Society's annual spring clinics. However, this year the committee recommended that due to shortage of funds, a lapse occur in this financial assistance during the current year of 1942.

In considering further efforts in postgraduate medical education in the field of cancer, the committee recommended to the Council on Scientific Work that either in 1942 or in the years immediately to follow, a cooperative effort be developed between the Committee on Cancer and the Council on Scientific Work to the end that the refresher courses of previous years in the field of cancer be re-established.

It has been the responsibility of this committee to prepare and distribute for the Women's Field Army material for speakers. During the last year the committee has caused to be created a new film strip and manuscript on cancer in Wisconsin. The committee reviewed earlier film strips which were available to physicians for use in discussing cancer before lay groups and felt that certain portions of the old film strips should be incorporated into a new one and that the relationship of cancer to other health problems be emphasized in the new strip. The manuscript and film strip as revised by the Committee on Cancer were used in the 1942 campaign of the Women's Field Army.

Functioning as the Executive Committee of the Women's Field Army in Wisconsin, the committee considered the following subjects:

1. Confirmation of appointment of the state commander of the Women's Field Army. The Executive Committee of the Women's Field Army directed that the reappointment of Mrs. G. E. Stoddart as state commander be confirmed.

2. Speakers' bureau for Women's Field Army. The Executive Committee recommended that the secretaries and presidents of county medical societies and program chairmen of these same organizations be urged to devote February and March scientific programs to the subject of cancer, and that the officers of the societies secure the names of speakers who would be available to fill engagements arranged by the Women's Field Army.

The advice and counsel of the Executive Committee of the Women's Field Army were sought by the commander with respect to an exhibit for use in connection with the county fairs and the State Fair. The Executive Committee appointed a subcommittee to investigate this available exhibit material. The subcommittee found upon investigation that the exhibit in mind was large and cumbersome, could be transported only by trailer or other similar form of shipment, and would necessitate the services of at least one man especially trained in its operation to supervise it. The committee felt also that to prepare the exhibit properly would require the gathering of a great deal of data and other material for display purposes either by members of the committee or the Society's office. For these reasons it recommended that at the present time the Women's Field Army not purchase this display material.

Other subjects considered by the Executive Committee were the conduct of an essay contest among juniors and seniors of high schools and freshmen and sophomores of colleges, on the subject of cancer. Also considered were possible changes in the organization and use of memorial funds.

The Administrative Committee of the Women's Field Army, which is composed of representatives of the Committee on Cancer and officers of the Women's Field Army, recommended to the Executive Committee of the Women's Field Army that the policy of limiting the activities of the Women's Field Army to those of a strictly educational nature be reaffirmed. This recommendation will go before the Executive Committee of the Women's Field Army at its fall meeting. Through its executive officer, Mrs. G. E. Stoddart, the Women's Field Army has expressed to the Committee on Cancer its appreciation for the continued cooperation of the committee and the offices of the State Medical Society in the conduct of educational work in our state. An invitation has been extended by Mrs. Stoddart to physicians to express themselves concerning the work of the Women's Field Army. She would appreciate receiving such comments at her offices in Beaver Dam.

ADVISORY COMMITTEE ON CARE OF CRIPPLED CHILDREN

J. B. MacLaren, chairman, H. L. Greene, J. O. Dieterle, H. A. Sincock

The chairman of the committee for the current year resigned his chairmanship in order that he might serve both the interests of the Crippled Children Division and the Society as pediatric advisor to the Crippled Children Division. The president of the Society appointed Dr. J. B. MacLaren, Appleton, as chairman and Dr. H. A. Sincock, Superior, as a member of the committee.

The subjects coming before the committee were so varied that the experience of each member in his special field (pediatrics, orthopedics, cardiology and general surgery) was of particular value to the committee as a whole.

Soon after the close of the Centennial Meeting, the committee convened to consider the proposal from the Wisconsin Heart Association to provide a cardiac survey of school children in selected areas and schools in the state. The committee was advised that federal funds had been made available for such a survey and the mechanics of conducting it had been considered by the Wisconsin Heart Association. The proposed survey would initially, at least, be conducted in Milwaukee, and on the basis of experience there, would be extended gradually into other areas in the state. Examinations were to be made by a member of the Wisconsin Heart Association or one selected by that Association, together with physicians from the local county medical society.

Extensive consideration was given to this question by the committee which asked that the Council be advised of its approval of such a survey provided:

1. The survey was conducted under the supervision and direction of the State Medical Society;
2. That before any surveys be made they first have the approval of the local county medical society affected;
3. That when each survey is made there be present a member of the Wisconsin Heart Association and a member of the local society.

By custom this recommendation was referred to the Council of the Society, which, because of the many problems connected with the military efforts of the nation, together with the fact that other surveys have been suggested in the field, has withheld action pending detailed study of the situation and the relative value of such activity at this time.

Orthopedic members of the committee reported that there still existed some congestion at the time the orthopedic clinics were held and recommended

that more stringent regulations be invoked to make certain that the exact number scheduled to appear for examination be known in advance of the clinic. If more than thirty patients were to appear, a second orthopedist was to be engaged for the clinic.

Convalescent Homes

Other questions coming before the committee related to the establishment of convalescent homes for those afflicted with rheumatic heart conditions and acute poliomyelitis and for the care of spastic children. The committee was advised that at the present time no facilities are provided in the state for the convalescent care of children suffering from rheumatic heart conditions. It is conservatively estimated that 1 per cent of school children have rheumatic hearts which means that approximately 5,000 children are suffering from such heart ailments in Wisconsin. Dr. MacLaren, chairman of the committee, appointed Drs. Kurtz and Tenney as a special committee to investigate the possibility of establishing a plan for the care of children suffering with cardiac conditions and to recommend the location and facilities for the establishment of a convalescent home.

The committee was advised that a gift had been made to the State of Wisconsin General Hospital to send certain of its personnel to Minneapolis to obtain training under Sister Kenny in the thermal treatment of poliomyelitis. Dr. H. M. Coon, superintendent of the State of Wisconsin General Hospital, who was present at the meeting, told the committee of experimental plans to set aside a small number of beds for children suffering from acute poliomyelitis. The committee viewed this activity favorably and suggested that *The Journal* of the State Medical Society carry a notice as to the availability of thermal treatment, with the understanding that such notice as was directed to the profession would be the only statement made. No reference was to be made as to the method of treatment to be given, or other data,—simply the fact that the hospital was equipped to accept and treat children suffering from acute poliomyelitis.

Mr. Frank Powell of the Crippled Children Division called attention to the problem which was being raised by the inclusion of spastics in the orthopedic schools.

In consideration of this question the committee felt that a number of spastic children enrolled in the orthopedic schools are not mentally equipped to carry on in that type of facility and recommended that in the accepting of spastic children a psychiatric examination should be made in order that a proper evaluation might be made of the mental status of these children. The committee directed Dr. Tenney to make a thorough study of the existing facilities for the care and treatment of spastics and for a mental appraisal of these children. Following this study a report is to be made to the committee.

COMMITTEE ON GRIEVANCES

Louis Fauerbach, chairman, W. A. Ryan, A. J. Patek

At the 1941 session of the House of Delegates, your committee recommended that the general subject of malpractice insurance be continued as a current topic of importance to the entire medical profession, and that continuous effort be made in this field in order that the profession might secure adequate coverage within normal premium limits. Your committee is conscious of the fact that this subject continues to be one of considerable importance within the profession, and consequently is of the opinion that the Society must regard the matter as one deserving more than occasional investigation. By and large, the committee is of the opinion that the attitude of the various groups concerned is wholly cooperative, but only through attention to certain fundamental problems can real progress be accomplished. This will continue to be a particular charge of the committee in its efforts on behalf of the profession. While the present state of national emergency cannot be considered as a wholly propitious occasion for involving the Society in further involved activities, it is felt that much may be surveyed during the course of the coming year which will ultimately lead to more satisfactory conditions prevailing with respect to this subject.

Your committee is particularly pleased to be able to report that the Supreme Court of Wisconsin did not incorporate the so-called expert testimony rule as was suggested in the fall of 1941 by its advisory committee on pleading and practice. Delegates will recall that the proposal was discussed extensively before them in their 1941 session, and that the Society filed a brief and through legal counsel presented oral argument on the matter on the last day of the Society's annual meeting that year. The proposal briefly summarized would have incorporated in the practice laws of the state provisions for the appointment of expert witnesses by the court upon its own motion or by request of either party. Such witnesses would have been permitted in all civil actions, but so far as the medical profession is concerned, its interests lay in those actions involving personal injury. That this constituted the major interest of the proposal is suggested by the fact that medical men are said to constitute at least 60 per cent of the experts who appear before courts. The Society opposed the enactment of this proposal which, although called procedural, would very frequently involve or even determine the principal rights of the parties who are litigating. The law, as was stressed in the argument made on behalf of the Society, would only have complicated further the already complicated subject of expert testimony, without curing any of the acknowledged limitations of the present situation. Physicians and other professional men would have been subjected to unfair treatment under the terms of the act which, as drafted, would in too many instances have tended

to favor a glib rather than a sound presentation. Our counsel made reference to the undesirable results observed in Europe which has for some time had court panels of so-called experts who tended to degenerate into little more than professional witnesses. We felt that the interests of public health, among others, would not benefit from such an enactment. It should also be noted that the organized bar of Wisconsin has gone on record against the proposed law whenever a full opportunity was presented for a discussion of its merits.

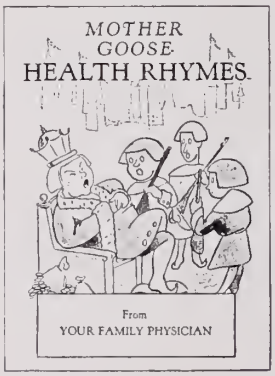
However, your committee feels that the delegates cannot consider this subject as one which no longer requires attention. The Minnesota experiment has now been operative a sufficient period to permit proper evaluation of its effect both as a procedure within the profession of medicine itself, as well as an informal principle of jurisprudence. It is the purpose of the committee to entertain a complete and detailed study of this and similar matters during the forthcoming year, that in 1943 the House of Delegates may be apprised of its conclusions and recommendations on the matter. While the committee understands the many problems assumed by the profession during this period of national emergency, it is felt that this particular subject matter is one of such pressing importance that it falls within a particular category of immediate importance during this coming year.

The committee calls the attention of the delegates to the fact that one of its members, Dr. W. A. Ryan of Milwaukee, is now in active service and has been unable to participate in the committee report to the delegates.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

C. J. Newcomb, chairman, W. J. Egan, J. A. Riegel

The committee's public health educational efforts have been directed into three restricted mediums, the first of which is the revision and further development of the film strip entitled "Health Achievements in Wisconsin," announced at the time of the Centennial Meeting of the Society.



Throughout the year the committee has endeavored in several ways to inform members of the Society of the availability of the film. This has been done through the pages of *The Wisconsin Medical Journal,* through letters to county medical societies and through the assistant secretary's showing the film to members of county medical societies and explaining to them that they might obtain it, together with a projector and manuscript, from the central office without cost.

The committee feels that throughout the period of the emergency we must continue our efforts of public health education in order that the great gains of past years may not be lost.

Press Releases

The committee has caused a news release to be circulated to the weekly and daily newspapers in Wisconsin once each week. Thousands of inches of newspaper space have been made available gratuitously to the people of Wisconsin, that accurate and reliable information on health subjects may guide the health habits of our citizens. There are 325 weekly and forty-five daily papers which receive this service of the committee.

Hygeia

An annual subscription to *Hygeia,* the health magazine published by the American Medical Association, is given to citizens holding an office of public trust in Wisconsin. Among those receiving the magazine are presidents of normal schools, state department heads and those in public office who are often confronted with questions and problems relating to health. The information contained in this publication is of material assistance in gaining an over-all picture of health problems, and helps them in their effort further to advance the health of our citizens. Repeated comments from recipients of this gift subscription indicate that the magazine is widely read by them and that they have found it indispensable in their work.

County Fairs

A second medium of public health education developed this year is the county fair exhibit. The committee acknowledges its indebtedness to the Ohio State Medical Society, the originator of this type of public health education. The committee has prepared three sets of exhibit booths which are composed of six panels on which appear colored nursery rhyme characters and below each of which appears a paraphrased nursery rhyme emphasizing some phase of health. The title of the exhibit is "Better Health—Its Rhyme and Reason." To be used as a part of the county fair exhibit the committee has prepared a printed booklet, four by five inches, composed of eight pages of the same paraphrased nursery rhymes.

The fair exhibits were shown at a number of county fairs and were enthusiastically acclaimed by the county medical societies.

Motion Pictures

The third activity of the committee has been a thorough investigation of the public health motion pictures which have been produced and are available through several sources in Wisconsin. One of

the continuing projects will be further appraisal of the motion picture films and, shortly after the annual meeting, the preparation and publication of a list of recommended public health motion pictures. This publication can be used by members of the Society in the development of public health educational programs for Parent-Teacher Associations, women's clubs, service organizations and similar public gatherings. The committee is amazed to discover the tremendous number of public health motion picture films that are available.

During the course of the year the committee reaffirmed its approval of the motion picture entitled "When Bobby Goes to School" and heartily recommends the showing of this sound motion picture, particularly to Parent-Teacher Associations and women's clubs. Another outstanding motion picture is "The Eye," a film dealing with the structure and care of the eye and the need for a competent examination by a physician. A similar film, "Seeing How You See," is recommended by the committee. Other outstanding films deal with the subjects of pneumonia, digestion and first-aid control of bleeding. This particular film will be particularly useful to members of the Society having charge of first-aid instruction. Another film of current interest during the emergency deals with home nursing. All of the above films are available through the Bureau of Visual Instruction, University of Wisconsin. A film of unusual merit entitled "Good Bye Mr. Germ" is available through the Wisconsin Anti-Tuberculosis Association.

THE COMMITTEE ON HOSPITAL RELATIONS

R. M. Kurten, chairman, R. M. Waters, M. L. Jones, J. E. Habbe, E. O. Gertenbach, Gorton Ritchie

At the 1941 session of the House of Delegates the report of the special Committee on Hospital Relations was presented by Dr. J. E. Habbe of Milwaukee. Dr. Habbe's report stressed the importance of friendly intercourse with hospitals as institutions affording facilities for the treatment of patients and urged the creation of a standing committee of the Society charged with the responsibility of being continually informed on the relationship of hospital institutions to the general field of care of the sick.

The committee has considered its function to be that of an agency of the Society created to study not alone the immediate problems that may be of concern but the long time significance of present day trends. During the first year of its organization as a standing committee of the Society a considerable amount of effort has been expended in the direction of ascertaining whether the program of the State Medical Society at its annual meeting could be in part developed along lines which would offer discussion of value to those having particular interest in the field of hospital relations. The committee has investigated the feasibility of discussions centered about such topics as the authorization required by professional procedures, certain phases of the problem concerning graduate education and the assistance that may be rendered in maintaining records necessary as a part of the accumulated professional data of hospital institutions. Several committee sessions have been devoted to the examination of this general program and the committee through its chairman and individual members has been in conference with the Council on Scientific Work to ascertain whether such procedures might in the future be incorporated in some portions of the annual meeting program. As a result of these endeavors delegates will note that on the final day's program a round-table luncheon has been scheduled on the subject of hospital administration and the practice of medicine. This is an experimental procedure to ascertain whether a demand exists for topics entirely professional in character but of a special interest to those participating in this general field of activity.

Your committee feels that there are many activities in which the State Medical Society is currently engaged that are of a special interest to the subject of its work. The Wisconsin Hospitals and Medical Payments Plan provides a working agreement between patients, physicians, hospitals and insurance companies to protect the hospitals and physicians in the payment of their services where an insurance settlement is involved. The work of the House of Delegates Committee on Nursing Problems involves the general subject particularly as it relates to nursing schools and certain activities in the field of nursing education that are of particular interest. During this period of national emergency the committee notes with satisfaction the cooperation offered by the Committee on War Participation appointed by the Council of the State Medical Society and the complete appreciation rendered hospital problems by the state chairman of the Procurement and Assignment Service. It points out that problems in these two fields are in many ways of joint concern and commends the organizations for their cooperative attitude. The program of the Committee on Industrial Health is one of considerable import in the field in which this Committee on Hospital Relations is itself involved. During the forthcoming year the committee is conscious that the tremendous demand made upon the organization of medicine to serve the armed forces and the civilian needs of the people is one which will tax the strength and facilities of the profession to its utmost. To some extent the everyday problems of both economic and professional character must be temporarily laid aside in order that every facility of the organization may be made available to the war effort of the country. Yet within the limits of practicability your committee intends to pursue its study and its efforts in this field and to that end intends to evolve further generally accepted principles.

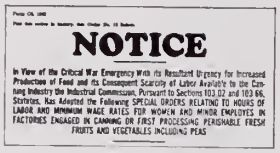
Your committee offers its suggestion to the House of Delegates that the field of hospital relations is one which offers an unusual opportunity for the con-

tinued progression of medicine in the interests of public health. Much remains to be studied and problems of the future cannot be wholly anticipated at the present time. No definite action is suggested by the committee, it being of the opinion that a progress report is all that is indicated at this time.

COMMITTEE ON INDUSTRIAL HEALTH

M. L. Jones, chairman, H. L. Greene, T. J. Howard, L. W. Hipke

The national emergency has had the one unanticipated effect of tending to condense into months industrial health programs visualized for accomplishment over a period of years. As a result, manufacturers as well as the medical profession, labor organizations as well as the individual employe, are conscious that the importance of production in relation to war effort is recognized to be of primary importance. The United States Public Health Service, the War Manpower Commission, the War Production Board and other governmental agencies have urged that the interest of the medical profession in the health aspects of production efforts be emphasized and their scope and program increased in the interest of the national welfare. It becomes apparent to the committee and to others that the program visualized over a period of years in the future must be carried forward now, not alone with increased vigor, but with broadened scope and effectiveness.


Form CIL 1000
Pursuant to Industrial Commission Order No. 13 Series

NOTICE

In View of the Critical War Emergency With its Resultant Urgency for Increased Production of Food and its Consequent Scarcity of Labor Available to the Canning Industry the Industrial Commission, Pursuant to Sections 103.02 and 103.66, Statutes, Has Adopted the Following SPECIAL ORDERS RELATING TO HOURS OF LABOR AND MINIMUM WAGE RATES FOR WOMEN AND MINOR EMPLOYES IN FACTORIES ENGAGED IN CANNING OR FIRST PROCESSING PERISHABLE FRESH FRUITS AND VEGETABLES INCLUDING PEAS

The program of the medical profession, as it relates to industry and as developed through the Council on Industrial Medicine of the American Medical Association, envisions the promotion and protection of the health and physical well-being of employes, not alone through the pre-employment examination, but through the broadening of that examination to the character of a placement procedure. In other words, when every sinew of the nation is called upon for its utmost in productive effort, the employe physically qualified for certain employment procedures should not be placed in a position for which he is physically unqualified.

Prevention of disease or injury is likewise most important through proper medical supervision, not alone over conditions of employment but the related environmental problems of the workers. The so-called "upside-down" worker presents an acute aspect of this problem, his week end most frequently being adjusted, at least in his own estimation, to the normal procedures of family life, while his workday becomes a work night with the attendant problems of sleep, nutrition, relaxation and general physical well-being.

Other problems of like concern involve the complete and wholehearted cooperation of the medical profession in the restoration of health and earning capacity to the industrial accident or disease patient, while other problems relating to the woman employe, the minor employe, and their employment conditions, offer much of concern in the war effort of the nation.

The Committee on Industrial Health conceives its responsibility to work arm in arm with those likewise interested in the problem. The State Medical Society, through this committee and with the complete cooperation of the county organizations, envisions a cooperative educational arrangement with representatives of manufacturers and others to promote the conservation of manpower in this general field. The problem in other phases necessarily must come to the attention of the Council on Scientific Work, which has noted in its report that it views favorably the development of an industrial health postgraduate clinic later in the year.

The Committee on Industrial Health is working in close cooperation with the officers and a special committee of the Dane County Medical Society to develop a pattern and a program embracing these general endeavors. The activity is detailed and involves the assistance of such groups as the mayor and council, associations of commerce, and organizations of merchants and others. Emphasis will be laid not so much upon the so-called physical examination as it will along lines generally outlined in the foregoing portions of this report, and the pattern developed will be available to all county societies in the near future.

The committee is conscious that the program calls for contributory activities on the part of the organized medical profession and the individual physician to an extent not yet wholly realized by the general medical profession. But the problem is not so much one of protecting the individual's health as it is that of providing the nation itself with a production to implement our armed forces which are now on all continents of the world and on the seven seas. To this cooperative effort, the committee commits the attention of the State Medical Society of Wisconsin and, at the same time, notes with considerable pride that Wisconsin has been cognizant of the problem through the leadership of individual physicians so that in this period of national emergency the organization is perfected and the planning and procedures are analyzed.

Through funds made available to the committee by the House of Delegates, this committee, in collaboration with the Conference Committee on Open Panels, distributed to in excess of 50,000 Wisconsin employers compensation panels for their respective counties. As was outlined in the report of the Conference Committee on Open Panels, the distribution of this great number of panels to employers in every county in Wisconsin has resulted in wider choice of physician by the employe. The Committee on Industrial Health has been particularly interested in the use of the workmen's compensation panels in con-

nection with the Wisconsin Physical Examination Program of the Industrial Commission. The only available list of Wisconsin employers is a card index file maintained by the Wisconsin Industrial Commission of all employers who have been in the past or who are at present subject to the Workmen's Compensation Act. In preparing the envelopes for mailing, a careful analysis of employers is required, as well as proper addressing of the envelope and subsequent sorting of each one by county in order that the proper county panel might be inserted. Several hundred requests for additional copies were received following the initial distribution of panels. Requests came from every county in Wisconsin and varied in number for from one to fifty copies.

Employment Examinations

The second primary activity of the Committee on Industrial Health has been the further development of the Wisconsin Physical Examination Program of the Industrial Commission, which provides for both pre-employment and periodic employment examinations. The committee has caused to be addressed a complete set of envelopes for all employers in Wisconsin in which will be placed educational material prepared by the committee with the assistance and counsel of the Industrial Commission, the Industrial Hygiene Unit of the State Board of Health, and the Council on Industrial Health of the American Medical Association. Employers will be urged to take full cognizance of the imperative need for a well considered industrial health program, and further, to accord their employes the same wide choice of physician in placement and pre-employment examinations as is the case when the employe is injured. In this connection they will be urged to use the panel of physicians supplied to all employers in the state by the State Society.

As was mentioned earlier in this report, a special committee from the Dane County Medical Society is working in close cooperation with the Committee on Industrial Health in the development of a pattern designed to focus community attention upon the need for an expanded industrial health program as the result of the accelerated industrial program attendant upon the extensive war effort under way in Wisconsin.

The features of the plan which is currently being considered by the special committee from the Dane County Medical Society are:

1. The active and enthusiastic support of the entire county medical society in calling attention of employers and the community to the need for the development of industrial health services.
2. Through the efforts of the trustees of the Dane County Medical Society the committee contemplates that the support be obtained of such groups as the mayor's office, Madison and Wisconsin Foundation, unions and others, to promote community interest in an intensive industrial physical examination program. Certainly one means of stimulating community participation would be the mayor's proclaiming an Industrial Health Week.
3. The trustees of the Dane County Medical Society will be requested to appoint a special committee to develop an industrial health exhibit to be erected in a central and prominent place in the county where large numbers of the public may have an opportunity to visit the exhibit. Investigations made by the Dane County committee have disclosed that similar exhibits presented in other communities have brought gratifying results. It is the plan of the committee to obtain exhibits from the Council on Industrial Health of the American Medical Association, the Industrial Hygiene Unit of the State Board of Health, Metropolitan Life Insurance Company, and others. This public industrial health exhibit, the committee feels, will offer an excellent opportunity to focus the attention of the public upon industrial health and on general health education.
4. A special circularization will be made to employers in Dane County by the county medical society, announcing the designation of the Industrial Health Week in which employers will be urged to view the health exhibits and to make it possible for their employes as well to see them. Attention will be directed to the fact that it is the wish of the Dane County Medical Society to assist Wisconsin employers to prevent absenteeism in industry, to reduce accidents, to decrease errors and so forth. The public's attention will be directed to the part that is played by proper nutrition and general health in the furtherance of the nation's war effort.
5. Concurrently with this general industrial health, educational effort, the value to industry of instituting a program for the examination of employes prior to placement in the factory or office, the advantages of periodic health examinations of employes and the facilities that are available to employers will be stressed that this might be done with the minimum loss of time and with the greatest possible gain to the employes and employers.

A program with as many facets as this will entail an extended period of time before its wide application will be evidenced in the state.

Canning Employes' Examinations

As a result of the shortage of labor in Wisconsin the State Medical Society was called upon to cooperate in a program which would make it possible for Wisconsin canners to employ seventeen-year-old boys during the canning season. The Committee on Industrial Health developed a physical examination

blank designed particularly for this purpose, and, in collaboration with the Wisconsin Canner's Association, appraised all canners in Wisconsin of the program by special bulletin. Before permitting the seventeen-year-old boys to work an unrestricted number of hours during the canning season, the Industrial Commission required that there be on file in the canner's office a statement that the protracted hours of employment would not result in undue hazard to the boy's health. This collaborative effort of the committee is further evidence of the profession's contribution to the war effort.

Postgraduate Education

The Committee on Industrial Health assisted the Conference Committee on Open Panels and the Council on Scientific Work in the development of a postgraduate program in the field of treatment of compensation injuries. This program is discussed in detail in the report of the Conference Committee on Open Panels.

Four-point Program

The directions in which the committee might expend its efforts are manifold. The committee felt, however, that for the present its effort should be limited to a four-point program as follows:

1. Continuation of all efforts to secure advancement of employment and pre-employment examination program.
2. Conduct of conference with industrial groups. As an amplification of this, it was thought that the following points might be discussed:
   a. Pre-employment and employment physical examination of employes;
   b. Health education in industry;
   c. Inclusion of topics of interest for employers on the evening of the industrial clinic program.
3. Assistance in the promotion of postgraduate courses directed toward treatment of compensation injuries, estimation of disabilities, and so forth.
4. Requesting county medical societies to set aside a part of their programs for emphasis on industrial health.

COMMITTEE ON MENTAL HYGIENE AND INSTITUTIONAL CARE

H. H. Christofferson, chairman, A. W. Bryan, S. K. Pollack

The By-laws of the State Medical Society charged this committee with the function of an advisory capacity to both the Society and cooperating agencies as to those means best designed to protect mental health and to alleviate mental illnesses. During the course of the year following the annual meeting of 1941 the committee is pleased to report its continued general activity in discharge of its responsibilities. In 1941, the committee brought to the attention of the delegates that the State Department of Mental Hygiene, as developed in previous years, had continued under the able guidance of Dr. G. E. Seaman until his death. During much of the year following, this division has been without a specific head but recently the appointment of Dr. W. J. Urben as director of the Department of Mental Hygiene has been announced by the Department of Public Welfare. The new director was born in Monticello, Wisconsin, and is a graduate of the University of Wisconsin Medical School. He is a member of the Dane County Medical Society, the State Medical Society, the American Medical Association and the American Psychiatric Association. He has had twelve years' experience in the field of mental diseases and came into state service in 1938 to assist the state in the study of a traveling psychiatric service. He had been senior physician at the Mendota State Hospital previous to his appointment as the director of the Division of Mental Hygiene.

The committee was consulted on the problem presented in reference to the general qualifications to be prescribed with reference to those who might be considered for appointment to this office, and the committee notes on behalf of the Society the cooperative attitude expressed by those in positions of authority.

During the last year the committee has noticed that marked criticism has been heaped upon those in charge of caring for the mentally sick and the mentally deficient. We improve and succeed through sound, well considered constructive criticism. Certain it is that members of this committee and those having the immediate care of the mentally afflicted are desirous of having the ideal reached in the care of those committed to them.

We have progressed markedly in our concept of the minimum care for those who are mentally ill. When first this was recognized as a community problem, the afflicted were placed in jails and there restrained many times by chains, and prior to the Civil War, prison beds, upon which these individuals were placed, were made of straw and no facilities made available to them of a sanitary character. They, like the domestic animals of the time, were bedded in straw and lived in their own excreta.

Today in Wisconsin there is a total state investment of well over $7,000,000 in institutions, such as the Northern Wisconsin Colony and Training School, the Southern Wisconsin Colony and Training School, the Central State Hospital for Insane, Winnebago State Hospital and the Mendota State Hospital. The taxpayers of Wisconsin expend annually over $1,500,000 in cash for the maintenance and operation of these institutions. It has been estimated that over $18,000,000 is invested in physical plants of county institutions for the insane, and approximately $1,900,000 is spent annually for the care of patients confined to county institutions. As of the date of the publication of this report there are 8,340 persons being cared for in county hospitals for the mentally ill and 4,000 being cared for in state insti-

tutions. The committee is particularly pleased to witness the marked improvement which has manifested itself at the Winnebago State Hospital. The roentgenologic, dental and surgical facilities would do credit to any modern institution for the care of the sick. Noteworthy improvements are found, too, in the provisions for surgery and for the care of the tuberculous insane. A separate wing is set aside for the care of the tuberculous patients, with separate serving and culinary facilities.

This commendation of the committee of the improvement which has been made in recent months is not indicative of the concept which the committee has ever held before it,—that we must progress to still higher standards for the care of those committed to institutions throughout the state. As will be noted later in the committee's recommendations, there are many improvements to be desired. It is the committee's intent during the ensuing year to meet with the trustees of county institutions in an effort to elevate the provision for care of the insane in county institutions. Many of the inadequacies which were so dramatically portrayed by the Subcommittee on Health and Disability of the Citizens' Committee on Public Welfare still exist and further means must be evolved to focus attention of the public on these inadequacies, that community action will impel their correction.

The recommendations of your Committee on Mental Hygiene and Institutional Care are as follows:

1. For the care of the tuberculous the committee urges that:
   a. There be made available from 200 to 250 beds for the mentally deficient, feeble-minded and epileptic.
   b. For the tuberculous insane separate provision be made for them to the extent of from 200 to 250 beds.
   c. A current survey should be made of all state and county institutions to which the mentally ill are committed, to ascertain those who are tuberculous. Except in a few isolated instances, such as the Winnebago State Hospital, no provisions are made for the separate care of the mentally ill who have tuberculosis. At the Winnebago State Hospital separate facilities have been established for the care and treatment of this type of patient. Following the survey of these institutions, a considered program for the care of the tuberculous insane can be evolved.
2. After an analysis of existing conditions the committee urges that increased emphasis be placed on the environmental investigations of the social problems presenting themselves in the patient's home, looking toward the rehabilitation of those discharged from institutions for the mentally ill. These investigations would also emphasize the prevention of recurrence and of repeated follow-up to the end that a complete recovery might be had of those discharged from institutions.
3. The committee feels that emphasis might well be given to the planning and study of an educational program in the field of mental hygiene and the care of the mentally ill, like those conducted by the Women's Field Army for the Control of Cancer, the Wisconsin Anti-Tuberculosis Association and others. The committee feels that through education much can be done to prevent and alleviate the load which is being placed upon the state and county institutions.
4. The committee recommends that separate facilities be established for the care of the criminally insane women.
5. At least one third of the population of our state institutions falls within the category of "dead load patients," or those suffering from chronic insanity. Theoretically, under our method for the care of the mentally ill, these should be discharged to county institutions. As present facilities of county institutions do not permit this, some facilities should be made available for the care of the chronic insane.
6. At present there are no separate receiving facilities at the Mendota State Hospital. The committee recommends the establishment of receiving facilities at this institution. The receiving cottages such as those established at the Winnebago State Hospital have demonstrated their usefulness.
7. Repeated emphasis has been directed by this committee, and the Subcommittee on Health and Disability of the Citizens' Committee on Public Welfare to the methods that are used in transporting the mentally sick to institutions. Complete disregard in many instances is given to the individual problem that is presented, and the patient is remanded to the care of the sheriff to be transported in such way as he may feel is indicated. The committee recommends that the physician advisor to the county judge should direct the manner in which patients should be transported, namely, whether by ambulance, car or train or whether they should be remanded to the care of the sheriff.
8. Every attending physician at county institutions should be encouraged to devote his talents and skills to further improving his knowledge of mental disease, that through this added effort and experience he will come to be looked upon in his local community, both by his colleagues and the public alike, as a psychiatric consultant.
9. Serious consideration should be given to the expansion of medical staffs at state institutions, to increased facilities for training physicians and nurses through their affiliate training, and to the establishment and expan-

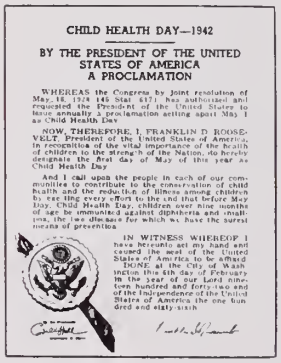
sion of training in occupational therapy. This committee on repeated occasions has emphasized that if we are progressively to elevate the standards of our institutions and their staffs, provision must be made for increased salary allotments.

10. The committee is fully cognizant of the fact that existing facilities do not permit adequate care, supervision and rehabilitation of the juvenile insane. Greater facilities must be set aside for this special type of mentally ill patient.
11. In furtherance of recommendation three above, the committee recommends that a studied effort be made to acquaint trustees and physicians throughout the state with the minimum standards of care at county institutions. Throughout the Department of Mental Hygiene there should be established what are considered the essential requirements for county institutions. The immediate goal of the committee is to visit, together with the Department of Mental Hygiene, not less than five county institutions, where joint conferences can be had with the local medical profession, the trustees of the institution, the Committee on Mental Hygiene and Institutional Care and the Department of Mental Hygiene.

COMMITTEE ON MATERNAL AND CHILD WELFARE

J. G. Taylor, chairman, J. J. Pink, A. B. Schwartz, J. W. Harris, Amy Louise Hunter, J. F. Wilkinson

Vital questions of importance to each member of the Society have been considered by the committee during the last year. Outstanding is the question of the provision of obstetric and pediatric care for wives of men in military and naval service. The proposal, together with the committee's recommendations, is presented later in this report. Other questions considered related to maternal deaths due to hemorrhage, the per cent of Wassermann tests made on pregnant women in Wisconsin, prenatal findings obtained from birth records, the study of cesarean sections performed in Wisconsin, the extent of immunization and vaccination programs in the state, the evolvement of a proposed plan for mental health and child guidance, stillbirths, prematurity, and lecturers for county medical societies.


CHILD HEALTH DAY—1942

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA
A PROCLAMATION

WHEREAS the Congress by joint resolution of May 18, 1928 (45 Stat. 617) has authorized and requested the President of the United States to issue annually a proclamation setting apart May 1 as Child Health Day

NOW, THEREFORE, I, FRANKLIN D. ROOSEVELT, President of the United States of America, in recognition of the vital importance of the health of children to the strength of the Nation, do hereby designate the first day of May of this year as Child Health Day

And I call upon the people in each of our communities to contribute to the conservation of child health and the reduction of illness among children by exerting every effort to the end that before May Day, Child Health Day, children over nine months of age be immunized against diphtheria and smallpox, the two diseases for which we have the surest means of prevention

IN WITNESS WHEREOF, I have hereunto set my hand and caused the seal of the United States of America to be affixed

DONE at the City of Washington this fifth day of February, in the year of our Lord nineteen hundred and forty-two and of the Independence of the United States of America the one hundred and sixty-sixth

Maternal Deaths

It is interesting to note that there has been a progressive decrease in maternal deaths in Wisconsin from 206 in 1936 to 151 in 1940 and, finally, to 133 in 1941. During the year, the committee directed that deaths resulting from hemorrhage be studied in order that the number of maternal deaths in Wisconsin might be lowered still further. The committee directed that the study be conducted on the basis of a "blind return," whereby the physician receiving a request for further data on cases in which he filed the death certificate would return this request without signature or identity. This method was found impractical as it was impossible to obtain a complete return of questionnaires from all physicians and therefore sound conclusions could not be drawn from the study. In view of this experience, the committee directed that a further study be made embracing all causes of maternal death. The physician would not be identified with the case report as placed before the committee.

Vaccination and Immunization

National figures in 1942 focused attention upon the need for smallpox vaccination and diphtheria immunization. The committee inserted in *The Wisconsin Medical Journal* an editorial on this subject, as well as a full-page reproduction of President Roosevelt's proclamation in which he called upon the people of the United States "to contribute to the conservation of child health and the reduction of illness among children by exerting every effort to the end that before May Day, Child Health Day, children over nine months of age be immunized against diphtheria and smallpox. . ."

The State Medical Society, through its Committee on Health and Public Instruction, has employed a number of means to urge that these procedures be continued. In the film strip entitled "Health Achievements in Wisconsin" emphasis is repeatedly placed upon the necessity for continued immunization against diphtheria and vaccination against smallpox and whooping cough.

Wassermann Tests

Preliminary data obtained from birth certificates indicates that there is a wide variance between counties in the percentage of Wassermann tests made on pregnant women in Wisconsin. Returns indicate a variance of from 3.3 per cent to as high as 89.5 per cent of pregnant women received the test. An effort was made to find some reason for the wide variance from one community to another. The committee felt that the data which was obtained from the birth certificates the first year was not sufficient to merit drawing any definite conclusions. It recommended that before conclusions were drawn a more intimate study be made of both these returns and those to be made in subsequent years, and after accumulative data is obtained, educational campaigns be directed within the profession in those

areas that consistently show a low number of Wassermann tests.

The committee discussed the possibility of legislation requiring Wassermann tests be made on all pregnant women but deferred action on this, feeling that through education there would be greater assurance of more universal use of the test.

Mental Hygiene and Child Guidance

The Bureau of Maternal and Child Health placed before the committee the problem of stimulating interest in mental hygiene and child guidance throughout the state and suggested as one means that trial or experimental clinics be established in two or three communities. At regular intervals a professional staff would be made available to which physicians, school authorities and social service workers could refer behavior problems, mental conditions and similar ailments for counsel and guidance. According to the proposal, reference would be predicated upon a physical examination by the family physician.

In considering this question, your committee felt that it very properly should be divided into two separate fields, namely, postgraduate medical education of physicians and the evolvement of standards or procedures to be followed in the clinics should this program be established. The committee directed that collaboration be established between it and the Council on Scientific Work, which is in charge of all postgraduate scientific education. Accordingly, the committee appointed as its representative Dr. A. B. Schwartz, who met with Dr. G. W. Krahn, chairman of the Council on Scientific Work, and Dr. Amy Louise Hunter, director of the Bureau of Maternal and Child Health.

A tentative proposal was evolved for postgraduate medical education, limited to a restricted number of communities until the effectiveness and desirability of the program could be determined. Briefly, this proposal for postgraduate medical education was as follows: one physician was to be selected from each county in southeastern Wisconsin to attend a postgraduate course planned to be extended throughout the year. These physicians would be selected on the basis of their interest in mental health and child guidance and would attend an afternoon and evening session in a nearby community to which would be brought outstanding teachers on these subjects. Tentatively, it was planned that this course would be held one afternoon and evening each week for four consecutive weeks and thereafter one afternoon and evening each month for the remaining eleven months. The committee deferred final action on the question of establishing these clinics in Wisconsin until a thorough study and appraisal could be made of child guidance clinics elsewhere and of the actions taken by such organizations as the Academy of Pediatrics and the American Psychiatric Association.

Soldiers' and Sailors' Wives

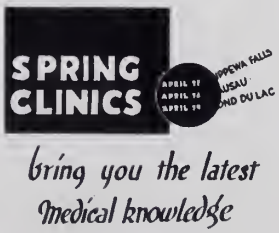
The Children's Bureau of the United States Department of Labor advised the Bureau of Maternal and Child Health that funds would be available for obstetric and pediatric care of wives whose husbands were in the armed forces and had a rank below that of a commissioned officer. With the knowledge that there would be encampments of soldiers and sailors in Wisconsin, the committee, together with the Bureau of Maternal and Child Health, gave extensive consideration to the many ramifications of such a proposal. The committee's initial recommendation was that these funds be used primarily to care for patients who did not have residence in Wisconsin and, therefore, would not have aid available with the facility that is possible when the person needing aid is in his county of residence. It was the further recommendation of the committee that an investigation be made to be certain that no other means of caring for these people were available, and that facts concerning the need be determined through agencies already established in the community where the request for aid was made. The Children's Bureau of the United States Department of Labor indicated that it did not favor financial investigations by local agencies, but rather desired that aid be granted on the statement of need.

As the committee's report is written, further conferences and negotiations are being had with representatives of the Bureau of Maternal and Child Health and with the Children's Bureau.

COUNCIL ON SCIENTIFIC WORK

G. W. Krahn, chairman, F. D. Murphy, C. J. Smiles, E. R. Schmidt, K. H. Doege, W. S. Middleton, E. J. Carey

The demands made upon the Council on Scientific Work have been more varied during the last year than in any year since its inception. In addition to the development of the scientific program, the scientific exhibits and the hobby show for the annual meeting, the Council on Scientific Work considered the following subjects which will be discussed in detail later: postgraduate education in mental hygiene and cancer, the development and presentation of the annual spring clinics, postwar refresher courses, the sponsorship of one-day scientific programs in numerous areas in the state, and, finally, the development of postgraduate clinics in industrial health.



Scientific Program

Due to war conditions and loss of medical personnel to the armed forces, unusual obstacles were

encountered by Dr. Erwin Schmidt, the member of the Council on Scientific Work in charge of the scientific program for the annual meeting. A concerted effort was made to develop a program with a continuity, as is evidenced by the several half-day symposia set forth in the scientific program. The round-table luncheons, which have proved to be one of the most popular features of the meeting, were increased in number and varied in character for the current meeting.

Scientific Exhibits

The director of the scientific exhibits, Dr. C. J. Smiles, has arranged for an expanded scientific exhibit section in the Main Arena of the Milwaukee Auditorium. Truly outstanding scientific exhibits have been assembled to present scientific information comparable in character to the material presented on a scientific program. Dr. Smiles feels particularly fortunate in securing the American Medical Association's Gold Medal Award exhibit of Dr. Eben J. Carey, dean of the Marquette University School of Medicine.

State-wide Hobby Exhibit

Also under the direction of Dr. Smiles, the Council will present in the area immediately adjacent to the scientific exhibits the first state-wide hobby show.

Postgraduate Clinics

The Conference Committee on Open Panels and the Committee on Industrial Health recommended to the Council on Scientific Work that there be established either one or a series of postgraduate clinics on industrial medicine, embracing such subjects as industrial dermatoses; the treatment of burns; traumatic eye injuries; crushing injuries of the extremities; traumatic injury to the abdomen and the treatment of various types of fractures. The program for such a clinic is now under consideration by representatives from the three committees.

For the third consecutive year the Council on Scientific Work has presented the spring postgraduate clinics. The clinics this year were held in Chippewa Falls, Wausau and Fond du Lac. War conditions necessitated a revision of plans so that the talents of more Wisconsin physicians would be used. Consequently, the faculty at the 1942 spring clinics was composed of seven Wisconsin physicians and one out-of-state guest speaker. The speakers and subjects presented are a published record in the pages of *The Wisconsin Medical Journal* and do not require amplification here. The Council on Scientific Work re-emphasizes its conviction that the spring clinics fill a gap that had existed for many years in postgraduate medical education in Wisconsin. Many commendatory comments concerning the clinics have been received by the Council on Scientific Work and from their own personal observations they recommend that the clinics be continued unless war conditions make their discontinuance imperative.

Slide Service

The Council on Scientific Work, at a meeting held just prior to the preparation of this report, received the suggestion that committee effort be directed toward the establishment of a scientific visual illustrative service in addition to the literature which is supplied to physicians throughout Wisconsin by the Medical Library Service. For some period Mr. Jerome C. Diebold, director of the photographic laboratory at the University of Wisconsin Medical School, felt that the clinical material photographed at the State of Wisconsin General Hospital was not reaching as many physicians in Wisconsin as would be possible if colored slides and standard black and white lantern slides were mailed to physicians in much the same manner as are books and periodicals from the Medical Library Service. Through a cooperative arrangement by the staff members of the University of Wisconsin Medical School, the Medical Library Service and the photographic department, a new service will be inaugurated in the near future to members in Wisconsin who desire to avail themselves of it. The lantern slides and colored transparencies are now being collected by the Medical Library Service, and as soon as a representative slide library has been developed, the service will be announced through *The Wisconsin Medical Journal.*

All clinical material which the staff feels is of value from a teaching standpoint will be photographed and catalogued at the Medical Library Service. Selected slides which are used by the teaching staff at the University will be duplicated and placed in the library, or, if not in current use by the teaching staff, will be placed in the library for loan service.

The Council on Scientific Work feels that this service will fill a long-felt need of physicians for visualizing information on specific subjects. For example, a physician may be called upon to present before his county medical society a subject such as "Common Skin Diseases of the Hand." The literature on this subject would be gathered by the Medical Library Service and slides, both in color and black and white, would be supplied to the physician by the photographic laboratory. Still another example would be in the case of a request by a physician for recent literature on "The Treatment of Pott's Fracture." This physician would be supplied with current literature on this subject, as well as photographic slides of the x-rays found in this type of fracture showing the progressive stages of union. Physicians desiring to avail themselves of this service may do so by sending their request to the Medical Library Service for literature and illustrative photographic slides.

Postwar Refresher Courses

The Council on Scientific Work is now investigating the best means of bringing refresher courses on diseases of the civilian population to physicians who

will return to Wisconsin communities. The Council will work in close cooperation with the Council on Medical Education and Hospitals of the American Medical Association on this project.

Mental Hygiene

In collaboration with the Committee on Maternal and Child Welfare, the Council on Scientific Work has considered further efforts in the field of postgraduate education in mental hygiene. It has recommended that an initial experimental program be developed in the southeastern corner of the state to make available an intensive postgraduate refresher course on mental hygiene and child guidance to physicians selected from the several counties. Tentative plans suggest that a special afternoon and evening program on mental hygiene be conducted on one day each week for four consecutive weeks, and that this, in turn, be followed by a monthly meeting on this subject.

One-day Clinics

The Council on Scientific Work has felt for the last several years that a gap still remained in its postgraduate efforts between the scientific program and exhibits of the annual meeting and the spring clinics, and feels that initially eight one-day clinics should be developed without delay, to be presented in a like number of communities.

THE COMMITTEE ON TUBERCULOSIS AND CHEST DISEASES

G. D. Reay, chairman, A. A. Pleyte, L. O. Simenstad

During the current year the committee considered means for increased efforts in the field of postgraduate medical education embracing not only tuberculosis but other diseases peculiar to the chest such as pneumonia, bronchitis, and cancer of the lung.

The second phase of the committee's deliberations was public education in the field of tuberculosis. Other considerations can be noted under the general subject of detection and progress of the disease.

Postgraduate Education

Consideration was given the extent of efforts directed to this field in the scientific program of the State Medical Society, *The Wisconsin Medical Journal*, the spring clinics, and the chest institutes of the Wisconsin Anti-Tuberculosis Association. The committee recommended to the Council on Scientific Work a minimum number of round-table luncheons be presented each day during the course of the annual meeting on chest diseases, embracing the subjects outlined above and that more emphasis be placed on the early diagnosis of chest conditions in *The Journal*.

This committee further recommended that a thirty-minute discussion of tuberculosis be included on the spring clinic program and that arrangements be made with either the Wisconsin Anti-Tuberculosis Association or the State Board of Health for the loan of their mobile 35 mm. (miniature film) for the spring clinics presented in Chippewa Falls, Wausau, and Fond du Lac. It was the committee's recommendation that physicians attending the spring clinics be urged to visit the trailer and, if possible, have a miniature film made of their chest. The committee was advised that the chest institutes of the Wisconsin Anti-Tuberculosis Association had proved to be an effective means of conveying to physicians in concentrated form information on the means and technic involved in making early diagnoses of tuberculosis.

Public Education

That the committee might become familiar with the present-day means of public education in the field of tuberculosis, sound motion pictures designed for presentation before the lay public were reviewed. It was felt that several of the films were excellent means of calling the public's attention to the early signs and symptoms of tuberculosis and the importance of early consultation with physicians. The Committee on Health and Public Instruction in its report refers to the educational films available through the Wisconsin Anti-Tuberculosis Association, the State Board of Health, and the Bureau of Visual Instruction at the University of Wisconsin.

Screening Surveys

Closely allied with public education are the screening surveys made of certain groups by the Wisconsin Anti-Tuberculosis Association and the State Board of Health for the detection of tuberculosis. Screening surveys of students and employes are made through the use of the mobile 35 mm. unit of the State Board of Health. The 35 mm. (⅞″ x 1¼″) film is then read by three independent readers and a report made to the person examined and to the physician whose name is given by the examinee. The committee was advised that this unit was dispatched to a particular community only after approval had been given by the county medical society in whose jurisdiction the survey was to be conducted.

The Wisconsin Anti-Tuberculosis Association's fluoroscopic unit was also employed in making surveys of school children, industrial employes and adults in specific racial groups.

Problems coming before the Committee on Tuberculosis and Chest Diseases are of a continuing nature and while a limited number of well considered recommendations were made during the last year, the committee feels that it has obtained essential background material on which can be based further advice and recommendations looking toward still further control of the incidence of diseases outlined.

ADVISORY COMMITTEE ON VISUAL AND HEARING DEFECTS

J. K. Trumbo, chairman, F. S. Cook, F. W. Kundert

In prior years, the major efforts of the committee have been directed to making studies of visual acuity tests for automobile drivers and cooperating with agencies interested in conducting hearing surveys through the employment of audiometric equipment by trained lay persons.

Auditory Surveys

No new auditory surveys were instituted during the last year, but follow-up work was carried on in Wausau and La Crosse where surveys had been conducted in 1940 and 1941. The committee was not called upon to assist further in this work as the Work Projects Administration removed the impetus which had been given this program by that organization.

Visual Surveys

Carried over from the previous year's deliberation of this committee was the question of visual tests of industrial employes. At a special meeting of all ophthalmologists of the Society on September 10, 1941, this question was discussed in some detail and a recommended program was presented from the officers of the Section on Ophthalmology and Otolaryngology and the Advisory Committee on Visual and Hearing Defects. The report, presented at this special meeting and subsequently to the complete Section on Ophthalmology and Otolaryngology, is as follows:

The Section on Ophthalmology and Otolaryngology of the State Medical Society of Wisconsin desires to be of immediate assistance to the Industrial Commission in the furtherance of the Commission's Physical Examination of Employes in Industry Program. To the end that employes may be assured the best possible determination of their visual acuity as part of that program, and to the end that industrial accidents resulting from faulty vision may be held to the low incidence that had been achieved prior to the emergency period, this section of the State Medical Society recommends:

That the officers of this section, together with the Advisory Committee on Visual and Hearing Defects, prepare for submission to the Council of the Society an industrial service plan wherein the employes may have a determination of their visual acuity through the employment of the existing panel prepared and distributed for use in connection with the Industrial Commission's Physical Examination Program.

As the officers of the Section on Ophthalmology and Otolaryngology and the Advisory Committee on Visual and Hearing Defects might have an expression of thought of the members of this section in the preparation of the program referred to, this section recommends that the following outline be used as the basis for preliminary discussions:

1. Wherever possible all employes should be given a screening test by the industrial nurse. The standards to be followed in conducting such a screening test should be evolved by these joint committees and incorporated as a part of the recommended plan.
2. If services of an industrial nurse are not available the screening test is to be made by the physician chosen by the employe from among those listed on the panel as limiting their compensation practice to the treatment of eye, ear, nose and throat conditions. Such screening tests are to be made in the physician's office under methods and conditions satisfactory to the employe, the employer and the physician. No charge is contemplated for this test.
3. The industrial nurse shall be provided, in addition to the standards suggested in (1) above, with a list of the common eye complaints that may be incorporated in a history chart at the time the screening test is made. This information will be of assistance to the examining physician when cases are referred to him for examination. This list of common eye complaints is to be compiled and incorporated in the recommended plan.
4. When routine employment and pre-employment physical examinations of employes are made and visual defects are discovered, such employes should be referred for further examination and study to the physician chosen by the employe from among those listed on the workmen's compensation panel as eye physicians.
5. Those employes who are found during the course of the screening test to have a visual defect are to be given either a manifest or a cycloplegic refraction for which the physician's customary charges will be made directly to the employer.
6. Where goggles are indicated for safety purposes, such goggles will be furnished to the employer on a cost plus a fitting charge basis. The charges will be paid directly by the employer.
7. The prescription will remain in the possession of the physician or an optician designated by the examining physician.

The Section on Ophthalmology and Otolaryngology amended this report so that No. 1 would read as follows:

1. Wherever possible all employes should be given a screening test by the industrial nurse, or one trained to conduct such tests as prescribed by the committee. The standards to be followed in conducting such a screening test should be evolved by these joint committees and incorporated as a part of the recommended plan.

The second action taken by the section was the entire elimination of Item No. 2.

Concurrently with the consideration of this subject by your committee and the Section on Ophthalmology and Otolaryngology, the Milwaukee Oto-Ophthalmic Society engaged in a study of this same subject through its Committee on Industrial Vision Tests. The report of the Advisory Committee on Visual and Hearing Defects and the Section on Ophthalmology and Otolaryngology was made to the Council with the recommendation that it be approved. Simultaneously with the receipt of this report the Council received a number of requests for the conduct of surveys and because of their wide implications and many instances of duplication and overlapping, the Council recommended that the entire subject matter of surveys be referred to the secretary's office for further extensive study and consideration.

Work Projects Administration

Your committee, through its chairman, participated in the extensive deliberations which were conducted to effect an acceptable set of principles for the state-wide health projects of the Work Projects Administration. This activity is set forth in detail in the report of the Special Committee on Work Projects Administration.

Visual Standards For Employes

Visual standards were worked out by the committee as follows:

1. Wherever possible all employes should be given a screening test by the industrial nurse or one trained to conduct such test as prescribed by the committee.
2. Visual standards shall consist of the following:
   a. Distant vision should be 20/30 or better.
   b. Near vision should be 14/21 or better (A.M.A. rating card).
3. The industrial nurse should be provided, in addition to the standards suggested in (1) above, with a list of the common eye complaints that may be incorporated in a history chart at the time the screening test is made. This information will be of assistance to the examining physician when cases are referred to him for examination. This list of common eye complaints is as follows:
   a. Do you have headaches often after using your eyes for close work?
   b. Do your eyes tire when used?
   c. Do you ever see double?
   d. Do you have burning or tearing of the eyes after use for close work?
   e. Have you ever had any eye troubles?
4. When routine employment and pre-employment physical examinations of employes are made and visual defects are discovered as listed above, such employes should be referred for further examination and study to the physician chosen by the employe from among those listed on the workmen's compensation panel as eye physicians.

A number of such surveys have been done for various plants in the state. The main difficulty so far has been that some personnel managers try to take advantage of the doctor in spite of the fact that this program has already involved a considerable monetary sacrifice on his part.

If the points laid down are adhered to, especially those referring to supplying industrial goggles and maintaining the prescription in the doctor's possession and a little patience is used in explaining how this plan really gives a medical eye service to industry, your committee believes the plan will function satisfactorily for all parties.

4. REPORTS OF SPECIAL COMMITTEES

COMMITTEE ON INTERPROFESSIONAL RELATIONS

A. E. Rector, chairman, J. L. Garvey, C. A. Evans, W. G. Sexton, J. S. Supernaw

The Committee on Interprofessional Relations was created following the 1941 annual meeting as a result of the prevalent feeling there expressed that the State Medical Society of Wisconsin should participate in such ways as might be possible in the formulation of policies which would impose cooperative and understanding relations between various professional organizations in Wisconsin.

The delegates, and subsequently the committee members, were cognizant of the action of the State Bar Association of Wisconsin with reference to supporting a proposal which involved the Expert Witness Law and activities elsewhere by other professional groups which involved fields in which the opinion of medicine had not been expressed but was necessarily involved.

The committee has, through its chairman and individual members, conducted a rather general survey of the field which should be entertained in a discussion of this general subject. It is felt that its responsibilities were primarily to scan the whole subject not for the purpose of developing any immediate constructive action in specific fields but rather to sense the whole problem in an effort to ascertain a practical avenue of approach if such should exist. The committee notes with satisfaction the activity of other state medical associations in fields involving not alone bar associations and their particular interests but matters involving pharmacists and other professional groups within the general field of treating the sick.

It becomes evident that many professional groups are not organized on a basis which assures any permanency of interest, while other groups are organ-

ized in such manner as to offer nothing more than periodic interests in various fields of activity. The committee was cognizant that should the State Medical Society undertake any specific activity during the year just past, it might be placed in the position where it would of necessity carry the burden of maintaining the program as a consistent matter of interest to the various groups concerned. While this in itself was not necessarily undesirable, the committee was thoroughly cognizant of the demands made upon the organization of medicine during this period of national emergency and doubted whether concrete activity should be undertaken until such time as the picture cleared and the facilities of the Society were more readily available to the normal purposes of the medical profession.

The committee concluded that there is much of value to be gained by the Society maintaining the continued interest in the subject of interprofessional relations, but the committee would be remiss in its duty to the general membership if it failed to call attention to the fact that much is already being done in this field, although not so specifically designated. The work of the Committee on Industrial Health and the Committee on Open Panels is but one example of this, while the work and activity of the Committee on Nursing Problems has been outstanding in its efforts to survey a field both complex and of tremendous scope. Work of various other committees could likewise be especially noted, but it is not felt necessary in that a moment's reflection will indicate that the subject of interprofessional relations has not been ignored by the medical profession during some years past.

The committee feels that this activity might be more actively correlated were one of the standing committees of the Society charged with continuing responsibility in this field. The committee, therefore, suggests to the House of Delegates that with this report the Committee on Interprofessional Relations be discontinued and that the broad functions which it has exercised during the years past be assigned to the Committee on Grievances or to such other standing committee of the Society as the delegates may determine by a simple resolution approving the contents of this report. Your committee feels certain that any of the standing committees charged with the further prosecution of this subject will develop much of value to the medical profession in the months to come.

COMMITTEE ON SAFETY ON PUBLIC HIGHWAYS

M. W. Sherwood, chairman, P. C. Gatterdam, A. C. Florin

The Committee on Safety on Public Highways was continued as a special committee of the president, by reason of favorable action of the House of Delegates in endorsing the program suggested by President Gunnar Gundersen at the annual meeting in September, 1941.

The committee feels that part of the obligation of the medical profession in Wisconsin as elsewhere is to engage in and direct public discussion that will tend to lead to generalized activity in a field that will reduce traffic fatalities and injuries throughout the nation. Insofar as the medical profession itself is concerned, it feels that proper health and medical procedures involved in this general problem are particularly within the responsibility of the physician. Your committee, meeting in Milwaukee late in 1941, undertook an extensive survey of the possibility of safety education and expressed its concern that automobile accident fatalities in Wisconsin at the close of 1941 totaled 870, with injuries of every character exceeding 10,769. Consequently, the committee suggested the possibility of developing a special one-day clinic in Milwaukee, Madison, or some other point in the state to which would be invited medical as well as lay representatives to discuss the ways and means by which the medical profession might be of assistance in this field. Because the cost of such a clinic would be prohibitive at this time, it was not considered possible of immediate accomplishment, but the thought is one which remains on the committee agenda to be reopened at some later date when the pressures of the national emergency are not such as to strain every resource of the medical profession. However, the committee is of the opinion that there are other means which may be adopted to serve the public similarly. At the present time the secretarial office in conjunction with the committee is surveying 35 mm. and 16 mm. films that may be available with the thought that those meeting the approval of the committee will be properly cataloged and physicians, having the opportunity to speak on matters of safety on the public highways, will have these films available to them for illustrative purposes at a nominal cost.

Also in the field of public education a survey is being conducted of the possibility of distributing appropriate news releases on this general subject to the papers of Wisconsin. It is felt by the committee that such an undertaking would be at little additional cost, and its benefits to the public would be marked. It is felt that over a period of time roundtable discussions can be prepared by the Society and made available to physicians and radio stations throughout the state.

Your committee is cognizant of a prevalent belief that the curtailment of the use of rubber and allied automotive necessities, together with the popular agreement to reduce speeds, will produce a better accident record. That this may be true is indicative in the committee's opinion that a great percentage of previous automobile accidents are of a preventable character, and merely substantiates the committee's opinion that an active undertaking on the part of the medical profession should be encouraged during the years ahead.

By suggestion to the Council, your committee supplemented its activities by the appointment of a subcommittee known as the Subcommittee on Chemical Tests for Intoxication composed of Drs. H. A. Heise, Milwaukee, chairman; and Paul C. Gatterdam, La Crosse. Frank L. Kozelka, Ph.D., Madison, served as an advisory member to the subcommittee. After discussion with representatives of the Bureau of Legal Medicine and Legislation of the American Medical Association and with legal counsel for the State Medical Society, the subcommittee proposed that the State Society in the forthcoming session of the legislature support a measure providing for the mandatory acceptance by courts of chemical tests of bodily substances for the purpose of determining the fact of intoxication. Your Committee on Safety on Public Highways finds itself in complete accord with this proposal, subject to the conditions suggested by the subcommittee:

1. Any of the recognized tests would be qualified under this general enabling clause.

2. The specific blood-alcohol content and its relationship to the fact of intoxication would be provided in the measure to correspond with that recommended by the American Medical Association's Committee for the Study of Motor Vehicle Accidents and the National Safety Council. The extent of blood alcohol would be proved either by direct tests or, if the direct blood test were not taken, by opinion testimony correlating the amount of blood alcohol as shown by the content in urine, breath, saliva or spinal fluid.

3. The bill would contain a provision that issuance of drivers' licenses or motor vehicle licenses or renewal of such license would be conditioned upon the applicant's consent to an examination should he be charged by any law enforcement agency with driving a motor vehicle while under the influence of intoxicating drink.

4. A proper protective clause relative to the liability and competence of one taking such tests.

The subcommittee and the committee recall the principle followed by the Society over a period of years that any legislative proposal suggested by a committee and endorsed by the House of Delegates be thereafter placed in the hands of the Committee on Public Policy for final determination as to the feasibility of its introduction. If it should be the pleasure of the House of Delegates to approve this legislative measure, the records of the subcommittee and of the committee as a whole would be turned over to the Committee on Public Policy that it might, if it determined that the introduction of such a measure should be sponsored at this time, provide also for the exact wording of such a bill.

Your committee suggests, therefore, that this matter be referred to the proper reference committee of the House with specific action thereon.

COMMITTEE ON WORK PROJECTS ADMINISTRATION HEALTH PROJECTS

J. B. MacLaren, W. A. Munn, J. K. Trumbo, R. M. Kurten, C. N. Neupert

The advice and the counsel of the State Medical Society were sought by the director of state-wide health projects of the Work Projects Administration that principles might be prepared upon which various health projects throughout the state could be operated. The proposed program as outlined by Mr. Joseph Rohr, supervisor in charge of state-wide health projects, would embrace a wide variety of health projects, and in order that the best possible advice might be given, the president of the Society, Dr. Gundersen, asked that the chairmen of several committees of the Society act as a special advisory committee to the state-wide health projects of the Work Projects Administration. Those appointed to this special committee were Dr. J. B. MacLaren, chairman of the Advisory Committee on Crippled Children; Dr. W. A. Munn, chairman of the Committee on Nursing Problems; Dr. J. K. Trumbo, chairman of the Advisory Committee on Visual and Hearing Defects; Dr. R. M. Kurten, chairman of the Committee on Hospital Relations and Dr. C. N. Neupert, representing the State Board of Health. Many hours were spent in conferences and committee meetings in order that sound principles might be evolved under which the various projects of the Work Projects Administration might be conducted. The activities which were tentatively embraced in the proposal from the Work Projects Administration were:

1. The training and supervision of nontechnical personnel in hospitals in order that the technical and skilled personnel might direct more of their efforts toward the actual care of patients.
2. The training of clerical assistance for city, county and school health departments.
3. Training and supervision of certified workers in dental health programs for school children and for adults.
4. Studies or surveys of health problems of school children such as:
   a. Rheumatic fever or cardiac conditions;
   b. Visual surveys and studies;
   c. Audiometric survey of school children;
   d. Nutrition;
   e. Ventilation and lighting of schoolrooms.

This committee found the personnel in charge of the development of these projects for the Work Projects Administration most cooperative and appreciative of the many technical and scientific problems.

In the Wisconsin plan which was forwarded to Washington, D. C., it was proposed, "The actual working procedures will be those determined by the official sponsors (State Board of Health and Bureau of Public Instruction) and cooperating agency or

agencies. Where medical or dental procedures are involved the basic plan shall originate through the state society or societies . . ." "Qualifications of the professional personnel must be approved by the interested professional society previous to assignment to the program." "Where medical or dental procedures are involved, then the basic plan shall conform with the principles laid down by the state dental or medical society in cooperation with the local dental or medical society, and at no time will any local program be operated that is not in accord with the basic plan of the state society."

War conditions have removed the emphasis that had previously been placed on this type of activity. The principles laid down by this special committee, approved by the Work Projects Administration and accepted by the national officers of this organization, can, however, be placed into immediate operation in the event that this organization is activated again on a wide basis.

5. REPORTS OF COMMITTEES OF HOUSE OF DELEGATES

COMMITTEE TO STUDY REVISION OF THE CONSTITUTION AND BY-LAWS

E. J. Carey, chairman, Charles Fidler, A. R. Tormey, H. E. Kasten, C. J. Brady

The Committee on Constitution and By-laws was appointed by the president of the State Medical Society of Wisconsin from among the members of the House of Delegates, by reason of a resolution introduced in that body at the 1941 session. The committee was directed to make a careful study of the Constitution and By-laws of the Society, and to make such recommendations for their revision as in its final judgment seemed proper.

The committee has considered the Constitution and By-laws in great detail, and as a result of its studies offers the following recommendations to the House of Delegates:

1. The purpose clause in Article II of the Constitution provides that the Society is impressed with the duty "to enlighten and direct public opinion in regard to the great problems of state medicine." It seems apparent to your committee that this causes a misconception of the true purpose indicated, and upon motion of Drs. Fidler–Tormey, carried unanimously, it is the recommendation of the committee that the word "state," as contained in that clause, be stricken. The committee is conscious of the fact that the proposal must lie on the table for one year before being acted upon.

2. The committee considered in detail the provisions contained in Chapter III, Section 2 of the By-laws with reference to the determination of the number of delegates to which a component county medical society is entitled. In order to clarify this provision, and without substantive change intended, the committee recommends to the House of Delegates that Chapter III, Section 2, be amended by adding the following paragraph thereto:

> "For purposes of this section, the number of fully paid members as of a date thirty days in advance of the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled."

3. The committee considered in detail the provision of Chapter VIII, Section 1, of the By-laws, with reference to the determination of the date by which the state dues shall be paid without holding a member to be delinquent. It was the unanimous conclusion of the committee that amendments are not indicated to either the Constitution or the By-laws, but that the proper provision of the By-laws contained in Chapter VIII, Section 1, the last sentence, be printed henceforth *in italics* and published in the January, February and March issues of *The Wisconsin Medical Journal.* The committee recommends to the House of Delegates that the secretary's office be so instructed.

4. To clarify further the responsibilities of the secretaries of the county medical societies, it is the unanimous recommendation of the committee that the last two sentences of Chapter XI, Section 8, of the By-laws be re-enacted as a part of Chapter III, Section 2, so that the directory provisions contained in present Chapter XI, Section 8, also shall appear as part of Chapter III, Section 2. The amendment recommended by the committee, therefore, would add to present Chapter III, Section 2, the following sentences:

> "The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions."

5. The House of Delegates will recall that Dr. James C. Sargent, Milwaukee, delegate to the American Medical Association, offered a resolution in the 1941 session of the House of Delegates of the State Medical Society, seeking instruction of the delegates to a resolution requesting proper amendment of the By-laws of the American Medical Association so as to require advance notification of business to be presented at each annual session.

In favoring adoption of the resolution, the Committee on Reports of Officers and Standing Committees of the House of Delegates recommended that a similar amendment be adopted so as to provide like machinery within the organization of our State Society. This committee has considered the subject and recommends adoption of an amendment to the By-laws of the State Medical Society of Wisconsin creating Chapter III, Section 9, reading:

> "Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not

apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates."

6. The committee finds that the mandatory provision contained in Chapter VI, Section 1, of the By-laws, requiring the Council to meet daily during the sessions of the House of Delegates, is impractical, feeling that the Council possesses knowledge of its responsibilities and duties so that it may meet as necessity demands, rather than by command. The committee, therefore, recommends that the following change be made in the first sentence of Chapter VI, Section 1:

"The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require . . ."

7. The committee discovered that while Chapter VII of the By-laws specifies the creation of a Committee on Cancer, there is no corresponding section within Chapter VII prescribing its duties and responsibilities. It is the unanimous recommendation of the committee that present Section 17 be renumbered as Section 18, and Section 17 be created to read:

"The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years."

COMMITTEE ON LIFE MEMBERSHIP

T. C. Hemmingsen, chairman, Irwin Schulz, Louis Fauerbach, C. A. Armstrong, A. G. Koehler

This special committee of the House of Delegates was appointed by the speaker of the House, Dr. Russell M. Kurten, to report to the current House its recommendations for clarification and interpretation of the By-law relating to life membership.

Throughout the last several years repeated requests have been made for the granting of life membership, with many questions being raised as to those eligible for and entitled to it under the existing By-law. The Council in 1939 asked that the House interpret this section of the By-law but found that there still remained a number of questions with regard to administering this portion of it. Therefore the Council requested the House of Delegates to give further clarification of this provision. The House felt that there were complicating factors that could be more expeditiously handled by a special reference committee of the House. Accordingly, Dr. Kurten appointed Drs. T. C. Hemmingsen, Irwin Schulz, Louis Fauerbach, C. A. Armstrong and A. G. Koehler as members of this committee.

The conclusions reached by this committee are set forth here:

Minutes of Meeting of Committee on Life Membership of the State Medical Society of Wisconsin, March 8, 1942

The preliminary information concerning the status of life membership in the Society was presented to the committee by the assistant secretary. Dr. C. A. Armstrong submitted the following resolution to the committee for consideration:

Resolved, That when a member shall have had membership in the State Medical Society for fifty years, or shall have reached the age of eighty years while in active practice, he shall automatically become an active honorary life member, and a certificate of membership shall be prepared by the Society so stating. Such member shall be relieved of further assessments and dues.

After rather extensive discussion, the following motion was made by Dr. Armstrong and seconded by Dr. Koehler:

The By-laws shall be amended so as to make possible the automatic granting of life membership to any physician who has maintained continuous membership in the Society for fifty years or who has attained the age of eighty years and who has maintained membership in the Society since graduation from his medical school.

Incorporated as a part of this motion was the wish of the committee that such a provision be prepared in advance of the meeting and submitted to the committee for a mail ballot. If unanimously approved, no additional meeting of the committee would be indicated.

A motion was duly made, seconded and carried, that there be stricken from the present By-laws the provision that a member must maintain his membership continuously in the State Medical Society for thirty-five years.

In addition, the Committee on Life Membership indicated that life membership might be granted to a member of the Society on the following basis:

A. As a condition precedent to the granting of life membership, the physician must have maintained continuous membership in the State Medical Society of Wisconsin or the county medical societies in other states where he may have practiced.

B. All recommendations for life membership must originate from the county medical society. Life membership may be granted when any one of the following four conditions have been met:

1. The physician is facing serious and prolonged illness;
2. He is in serious financial straits;
3. He is totally disabled;
4. He has retired from practice.

This life membership, or what might more properly be termed waiver of dues, would be an annual affair carried from year to year with a reassessment

of the condition annually. Dues would be remitted so long as the physician was totally disabled, in serious financial straits, or had retired from practice.

The above recommendation to the House of Delegates was approved by motion of Dr. Koehler, seconded by Dr. Fauerbach, and carried.

The committee wished to emphasize that all recommendations for remission of dues or life membership should first be made by the county medical society and subsequently approved by the Council.

It was moved by Dr. Fauerbach and seconded by Dr. Schulz that an order of business be instituted in the Annual Dinner proceedings as a recognition to those members who had maintained continuous membership in the Society for thirty-five years. Incorporated as a part of the motion was the wish of the committee that a special certificate and plaque be given to the physicians indicating that they had maintained membership in the Society for a period of thirty-five years.

Summary

In summary, two actions were taken by this committee:

1. Automatic life membership to physicians who had been in practice for fifty years and maintained continuous membership in the Society, or who had reached the age of eighty years.
2. Formal recognition in the Constitution and By-laws of the provisions for the waiver of dues.

Your committee respectfully submits the following amendment to the By-law to make the necessary changes in event the House adopts the committee's recommendations:

Proposed Amendment to By-law Relating to Dues and Assessments

Resolved, That Chapter VIII, Section 1, of the By-laws of the State Medical Society be amended by striking therefrom in its entirety Paragraph Two and substituting the following:

"An active member who shall have attained his eightieth year and shall have been a member of his county medical society in Wisconsin or elsewhere in the United States continuously since beginning the practice of medicine, or who for fifty years shall have been continuously a member of his county medical society in Wisconsin or elsewhere in the United States, shall, upon establishing the above facts to the satisfaction of his county society, and upon the recommendation of such society, be granted the status of a life member. Such member shall enjoy full membership privileges, and shall be exempt from the payment of further dues or assessments, and a certificate of special membership shall be issued to him annually.

"An active member in good standing in his county society may, upon the recommendation of such society, be granted affiliate membership with full voting and other privileges where one or more of the following conditions exists: retirement from practice; physical or other disability of a character preventing the practice of medicine; a serious and prolonged illness; or financial reverses. Affiliate membership shall be on an annual basis only, and a member must be recommended each year for such special status by the secretary and president of his county medical society following a review and reassessment of his particular situation. An affiliate member shall enjoy full membership privileges and shall be exempt from the payment of dues and assessments during the year in which he is granted such status, and a certificate of membership shall be issued to him for such year.

"An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership."

COMMITTEE TO STUDY PROBLEMS RELATING TO THE MEDICAL PRACTICE ACT

R. G. Arveson, chairman, E. J. Carey, W. S. Middleton, C. A. Dawson, C. D. Neidhold

In his address to the House of Delegates at the 1941 annual meeting of this Society, President Gunnar Gundersen noted the situation pertaining to the Medical Practice Act of this state, particularly as concerned its enforcement. He offered the thought that the problem was one of sufficient importance to call for the creation of a special committee whose purpose it would be to "study the matter thoroughly . . . with the view of bringing recommendations to this body at its 1942 annual meeting so that proper steps may be taken to make necessary provisions for the amendment of the Medical Practice Act at the next regular session of the legislature in 1943. This study should go further in respect to reappraising all aspects of the act as well as the composition of the Board of Examiners itself."

The delegates will recall that acting upon the favorable recommendation of its reference committee, the president was directed to appoint such a committee with the general responsibilities suggested by the president. Your committee has functioned along the lines so laid down for it. It has studied in detail the various provisions of the Medical Practice Act, and to aid it in evaluating the Wisconsin law, it has directed a detailed study of those acts in such states as offer situations comparable to those in Wisconsin. Your committee finds a wide difference between these various acts, largely arising out of historical reasons, but with a consequent variation in the delineation of the various limited fields of treating the sick. The entire subject of the Medical Practice Act involves a field not alone exacting, but comprehensive. Fundamentally, it involves a public health law of Wisconsin, created under the police powers of the state, as one in which the health interest of the sick and well alike is to be properly protected. This notable fact is present in the Wisconsin law as well as in many others—a

state agency is charged with its enforcement with the practical effect that local agencies otherwise responsible have left the administration of the law largely up to state authorities. Regardless of the responsible agencies at the state level, the funds provided for the purpose of enforcement have never been sufficient for the agency to consider more than lip service to their responsibilities.

The committee does not feel it necessary in a formal report to enter into detailed discussion of this phase of the problem. That the Medical Practice Act is deserving of enforcement stands admitted from the fact that it is a law of the state. Every duly licensed physician in the State of Wisconsin knows of daily violations which are unrecognized by the public, casually ignored by apathetic local officials, and too numerous to permit of effective action by state agencies.

A house built upon sand offers neither safety nor permanence to its inhabitants; a good law, the administration of which is insufficiently financed, offers false security to those seeking or expecting the haven of its protection. So is it, in your committee's judgment, with reference to the Medical Practice Act in Wisconsin.

Your committee notes further the antiquated procedure for the appointment of members of the administrative board, which has existed virtually since "time immemorial." To support its conclusion the committee notes that under the present statutes, of the eight members of the board, three shall be allopathic, two homeopathic, two eclectic, and one osteopathic. The committee also calls the attention of the delegates to the fact that the members of the board are appointed for four-year terms and need not, other than as the opinion of the appointive official dictates, be those recognized within the medical profession as men suited to carry the responsibilities of enforcement of the Medical Practice Act.

Your committee feels that there are other portions of the act which, if amended, would better carry out its intended purposes. But a familiar axiom is applicable that even a poor law wisely administered is better than a good law poorly administered. The Medical Practice Act in Wisconsin, by and large, is a good law. That it fails in many of its purposes is no reflection on those charged with its administration, but leads those who have studied the problem inevitably to the conclusion that lack of financial support is the main cause of this fault. It may be argued that the Society should urge larger legislative appropriations to cure this situation. The record will show that such has been the position of the Society time and time again.

However, the delegates should recognize that the Medical Practice Act, like many another police law, is not one which dramatically demonstrates its own public value. There are many laws on the statute books of the state, and in the complexities of government today it is small wonder that some of them are more than momentarily lost from view in the legislative halls.

Your committee notes with satisfaction, however, that the medical profession in Wisconsin as elsewhere, has not shirked a responsibility clearly its own in the final analysis. The history of medicine is replete with examples which need not be stated here. Consequently, your committee holds to the conviction that at the forthcoming session of the legislature the Society should stand sponsor to a measure designed to modernize the structure of the State Board of Medical Examiners in the first instance, and in the second, to provide that agency or any other agency which may be subsequently charged with the enforcement of the Medical Practice Act with a sufficient wherewithal to perform its duty. Such a measure should call for the annual reregistration of licentiates of the board, including physicians not already under such a provision, the annual fee to be moderate but the total of which will be sufficient for the purposes outlined. The outline of such a proposal has now been prepared. If the House of Delegates concurs in the committee recommendation, the findings and suggestions of this committee would be delivered to the standing Committee on Public Policy, to which is delegated by custom the duty of making the final determination as to the ultimate position of the Society.

In conclusion, your committee notes with regret the inability of Dean Middleton to participate in its work. As the delegates no doubt know, Dean Middleton is now with the armed services of his country. The committee is cognizant of its and the Society's loss in not having the benefit of his counsel and thoughts in this general problem of public health.

COMMITTEE ON NURSING PROBLEMS

W. A. Munn, chairman, H. M. Stang, Burton Clark, Jr., F. A. Stratton

Immediately following the close of the Centennial Meeting, the Committee on Nursing Problems met to determine the course which their studies were to take during the ensuing year. In so doing the committee concluded that any change in the amount or standards of nursing education was a national problem and that of necessity any changes that might be instituted would have to be considered from a national level. Involved as part of the considerations of the committee in reaching this conclusion was the fact that licensure of nurses is based on existing standards between states and these standards for the most part are universal throughout the nation. To institute a change, decreasing the standards or

NURSES AIDES CORPS

placing emphasis on one portion of the training of nurses to the exclusion of other portions of the curriculum would result in Wisconsin-trained nurses finding difficulty in obtaining reciprocity with other states.

The committee's previous studies disclosed that a number of nursing schools had been discontinued due to the fact that they did not have available the facilities or teachers to carry forward the didactic or curriculum work that is required by the Bureau of Nursing Education of the State Board of Health. In an effort to assist in finding a solution to this problem, the committee made a study of the possibility of dividing the curriculum of the nurses' training into two fields: (1) the classroom and (2) practical or bedside training. Two available sources for curriculum training were considered as possibilities by the committee: (1) the teachers' colleges throughout the state and (2) the vocational schools in many of the cities.

In order that this possibility might be explored more thoroughly the committee invited the following personnel to meet with them: Mrs. Edith Partridge, Cudahy, secretary, State Nurses Association; Mr. E. G. Doudna, Madison, representing the State Teachers Colleges; Professor J. G. Meyer, president, Milton College; Dr. R. L. MacCornack, Whitehall; Dr. Carl Eberbach, Milwaukee; Dr. Eben J. Carey, dean, Marquette University School of Medicine; Dr. W. D. Stovall, Madison, Laboratory of Hygiene; Miss Cornelia van Kooy, Madison, Bureau of Nursing Education; and Dr. R. M. Kurten, Racine, speaker of the House of Delegates of the State Society. Representatives of the Committee on Nursing Problems were also invited. Present members of the Bureau on Nursing Education are Miss Leila I. Given, director of nursing education, and Miss Adele G. Stahl, assistant supervisor.

After extensive consideration of this question by the various representatives it was concluded that for the present at least it did not appear that these means of education would be adaptable to the training of nurses.

Representatives of the Wisconsin Nurses Association at this meeting stated that they recognized that a problem existed in rural and semi-rural areas for the provision of nursing care in the home. It was their feeling, and this feeling was concurred in by your Committee on Nursing Problems, that a mutual study should be made looking toward ultimate solution of the problem.

Since the last meeting of the House of Delegates two special phases of the civilian defense program have been developed affecting the provision of nurses and nursing care in the state. These two programs are the procurement of nurses' aides and the instruction in home nursing. Some communities in the state have begun the training of nurses' aides in hospitals. Those who enroll in this program agree to take a course of eighty hours of training and, during each year while they remain active, to give a minimum of 150 hours per year to the institution which trains them. This activity is of a purely voluntary character and carries with it no remuneration whatsoever. It is a contribution of the civilian population to the war effort.

Throughout Wisconsin courses have been and are being given in home nursing. Through this course mothers and others will be better able to render good nursing care to members of their families or others who become ill.

Your Committee on Nursing Problems recommends:

(1) That the delegates of this Society to the American Medical Association, collaborate with the committee in the preparation of a suitable resolution for introduction by our delegates to the House of Delegates of the American Medical Association. The committee recognizes that the intervening period may of necessity change that which might be recorded here. In order that the House might have knowledge of the general content of such a resolution, the committee recommends that unless a change seems wise in the light of then existing circumstances, such a resolution should state that the committee has found that revisions are indicated in the educational and training curriculum of nurses but that such revisions are national in scope rather than limited to a single state. They are national in scope due to reciprocity provisions in nursing licensure.

(2) That the House of Delegates provide for a continued study of war problems associated with the availability of nurses, the participation of hospital staffs as faculties in the nursing school and the need for enrollment of greater numbers in nursing schools.

(3) That a thorough painstaking study and consideration should be given during the war to the distribution of nurses and nursing service following the war. This study should be made in close cooperation with the immediate groups and agencies affected.

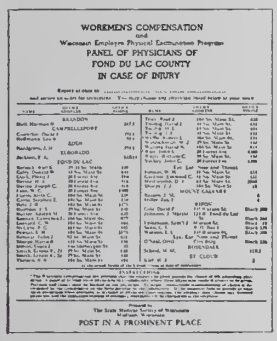
In summary, the committee wished to express to the House of Delegates its conclusion that ultimate solution of the problem of making nursing care available in all communities in our state is contingent upon a sympathetic study of the problem by the profession of medicine, representatives of the nurses, the Bureau of Nursing Education, hospitals and others. In the ensuing year it is anticipated that the spirit of cooperation will be developed still further.

6. REPORT OF COMMITTEE OF THE COUNCIL

CONFERENCE COMMITTEE ON OPEN PANELS

T. J. O'Leary, chairman, R. M. Kurten, Mr. E. E. Langworthy, Mr. C. W. Kroening

The Conference Committee on Open Panels has for three consecutive years witnessed the preparation and distribution of workmen's compensation panels permitting wide choice of physician by the injured employes. At the outset the conference committee anticipated that a number of years would of necessity have to pass before wide acceptance by the employers of the open panel agreement could be expected. Acceptance of the open panel agreement and wider choice of physician to injured employes are evidenced by increased demands for additional copies of panels by employers throughout Wisconsin. Insurance company members of the conference committee report also that more physicians treat compensation cases now than ever before in the history of the Wisconsin Workmen's Compensation Act.


WOREMEN'S COMPENSATION
and
Wisconsin Employers Physical Examination Program
PANEL OF PHYSICIANS OF
FOND DU LAC COUNTY
IN CASE OF INJURY

POST IN A PROMINENT PLACE

In order that a physician entering the armed forces of the United States would not lose his identity as a practicing physician in the community, the conference committee directed that an identifying mark precede the physician's name indicating, with proper notation, that he was in the armed forces of his country.

The broadening of the choice of physician developed concomitant responsibilities. It then became the profession's responsibility to assure those who selected their physician from the panel that such physician would be competent to treat the condition presented. In order to discharge this responsibility the committee recognized the value of postgraduate medical education in the treatment of the more frequently encountered compensation diseases and injuries. Your Conference Committee on Open Panels therefore recommended to the Council on Scientific Work that there be established one or more postgraduate clinics on industrial injuries to be conducted in a manner similar to the annual spring postgraduate courses. The Committee on Industrial Health concurred in this proposed program, as did the Council on Scientific Work. The recommendation of these three committees was, in turn, approved by the Council of the State Society. Therefore, a postgraduate course on industrial injuries and diseases will be presented under the sponsorship of the State Medical Society of Wisconsin.

During the current year the Conference Committee on Open Panels suspended publication of the specialty panel, as it was found not to be as reliable a reference source as the committee had anticipated.

The committee has received more complaints and cases for arbitration during the last year than in previous similar periods. Cases coming before the conference committee fall into three main categories: (1) disputes owing their origin to the question of payment for services rendered; (2) failure of panel physicians to make prompt return of required reports; and (3) the question of obtaining consultation.

A twofold educational program remains for the conference committee. This effort of the committee will be directed simultaneously to members of the Society and to insurance companies and their compensation insurance adjusters. There are a number of physicians who are not thoroughly conversant with all of the provisions of the open panel agreement, and a similar situation exists with respect to insurance agents, adjusters and representatives.

The committee acknowledges its sincere appreciation for the cooperative assistance of Mr. Harry Nelson, director of the Compensation Division of the Industrial Commission. He has cooperated to the fullest extent and on every occasion that the committee has sought his advice, counsel and aid.

COMMITTEE ON VOLUNTARY SICKNESS INSURANCE

C. D. Neidhold, chairman, H. J. Lee, D. H. Witte

In the interim which has elapsed since this committee made its last report to the House of Delegates it has considered two specific proposals for prepaid medical care in Wisconsin. In addition, it has directed its investigations in the general field of voluntary sickness insurance.

Medical Service Plan Conference

A development of interest to the medical profession, not only in Wisconsin but throughout the United States, was the Conference on Medical Service Plans which was held at the headquarters of the American Medical Association in February of this year. This conference was an initial effort to make possible the free interchange of experience by state societies engaged in the field of medical care.

One of the significant observations noted at this conference was the fact that medical service plans were retrenching whatever efforts had been made

in the field of complete coverage, that is, an insurance policy that would provide the insured with all of the services of a medical doctor. On the other hand, great emphasis was placed on the limited type of service benefit plan providing such restricted coverage as surgical benefits. Several communities have experienced the same difficulty as was evidenced in Wisconsin of interesting the public in purchasing complete coverage. The premium was greater than the public was ready to pay at that time.

Commercial Insurance Companies

Prepaid sickness insurance available through regularly licensed commercial insurance companies continues to expand. Some authorities state that commercial insurance companies indemnifying the insured in cash have paid benefits totaling approximately $365,000,000 a year. For the most part this type of coverage embraces only hospital and surgical benefits and when it was inaugurated a group of the outstanding insurance companies interested in it formed what is known as "The Group Conference." The Group Conference agreed that initially, at least, the policy provisions, extent of coverage and premiums would be identical. There would then be a pooling of experience and subsequently, perhaps, a varying type of policy. The experience of the members of The Group Conference appears to be satisfactory, as the rates initially charged have not been raised nor have the premiums been lowered. The benefits in some instances, however, have been increased, indicating that the premium has been adequate. The premium usually charged is 45 cents per month for the employe. Upon injury this pays to him a total of $150 in surgical benefits during any one year. For the most part the commercial companies have not encouraged coverage for the employe's family. In some instances the experience with these insureds has been so adverse as to cause a sharp revision of the premium rate.

Farm Security Administration

At the close of 1941 representatives of the Farm Security Administration reopened negotiations for the establishment of a trial plan in prepaid medical care in Wisconsin. The Farm Security Administration recommended that if possible such a trial plan be located in Monroe County. Your Committee on Voluntary Sickness Insurance conferred on repeated occasions with representatives of both the county medical society and the Farm Security Administration, and this resulted in offering to the Administration a plan of coverage for their standard loan clients. The salient points of the plan offered to the Farm Security Administration by the Committee on Voluntary Sickness Insurance and the Monroe County Medical Society are as follows:

1. Farm Security Administration families would be afforded free choice of physician from among all members of the Monroe County Medical Society who indicated that they wished to participate.
2. Ninety per cent of the families who are standard loan borrowers of the Farm Security Administration must subscribe to the plan before it could be placed in operation.
3. The premiums to be charged would be $34 per year per family. One dollar of this sum would be placed in an administrative fund. Twenty-two dollars would be immediately available for payment of professional services. If this premium did not permit the payment of 75 per cent of the normal schedule of fees in Monroe County, then such portion of the remaining $11 of the annual premium would be used as to make possible the full payment of 75 per cent of the normal schedule of fees. If the $11 is not used the subscriber families would receive a refund of either the entire $11 or such portion of this fund as was not needed for payment of services.
4. The services to be included were "the professional services generally rendered by physicians and surgeons of Monroe County." The plan does not embrace payment for hospital care, biological preparations, medical supplies, drugs and similar items.
5. Should a subscriber to the plan suffer illness of an emergency character while out of the county, he would then be eligible for reimbursement in an amount similar to that which would be currently remitted to physicians in the county for similar services.
6. A committee from the membership of the Monroe County Medical Society would administer the medical aspects of the plan and would audit all statements for services rendered to subscribers.

The complete plan as submitted to the Farm Security Administration appears as an appendix to this report. The Monroe County Medical Society, the Committee on Voluntary Sickness Insurance and the Council of the State Medical Society have, in accordance with the procedure outlined by the House of Delegates at its 1940 and 1941 meetings, approved this experimental plan for voluntary sickness insurance. The plan has been submitted to the Farm Security Administration, and in acknowledgment of its receipt Mr. J. F. Machotka, regional health specialist of the Farm Security Administration, commended the cooperation of the profession in Wisconsin when he stated:

UNITED STATES DEPARTMENT OF AGRICULTURE
Farm Security Administration
Milwaukee County Court House—Sixth Floor
Milwaukee, Wisconsin
July 28, 1942

Mr. C. H. Crownhart
Secretary
The State Medical Society of Wisconsin
Madison, Wisconsin

Dear Mr. Crownhart: I wish to thank you for your letter of July 23rd with which you enclosed a copy of the State Medical Society's new plan for medical care to benefit Farm Security Administration families in Monroe County. In order that we may have sufficient copies to study the plan by our Chief Medical Officer and the Regional Staff, it will be appreciated if you would forward my office at least two additional copies.

My own personal impression is that the Voluntary Sickness Insurance Committee, the district councilors and your office have done a lot of hard work on this very comprehensive plan. I am gratified especially to see the introduction of some new and desirable features; as for example, the conference committee which will be represented by both the physicians and the participating families to assure the satisfactory operation of the plan, the monthly submission of statements by the cooperating physicians but with quarterly payments and the designation of a group of consultants from among the cooperating physicians.

Again, I wish to assure you of our appreciation of the very considerable thought and effort that has gone into this plan by the officers, the Voluntary Sickness Insurance Committee and the district councilors of the State Medical Society of Wisconsin. In a short time you may expect to hear from the Regional Staff concerning our further comments regarding this plan.

Yours very sincerely,
J. F. MACHOTKA
Regional Health Specialist

Sheboygan County

An employees' association in Sheboygan County requested the Sheboygan County Medical Society to provide them with prepaid medical care in lieu of a policy of a standard commercial insurance company then in effect at the plant. The county medical society directed that a special committee from that society confer with the Committee on Voluntary Sickness Insurance to explore the possible types of prepaid medical plans that might be evolved on an experimental basis to provide the employes with prepaid medical care. The Committee on Voluntary Sickness Insurance, in collaboration with the representatives from the Sheboygan County Medical Society will, if this committee is continued, evolve a plan for submission to the Council of the State Society, and subsequently the decision of the Council and the committee will be submitted to the Sheboygan County Medical Society.

American Medical Association

The committee feels that this has continued to be throughout 1942, and will yet remain, one of the most important questions for study by the Society. The American Medical Association, through its Bureau of Medical Economics, has seen fit to assign one whose function it is to correlate the developments in this field and to study and correlate the findings that have been evolved out of the experiences of state societies and others who have established plans for voluntary sickness insurance. Evidence of the fact that this question is one which it is imperative be given continued study is that in the last year two concrete proposals for prepaid medical care in Wisconsin have been advanced to this committee. Further evidence of the necessity for continuance is the fact that the profession will now have accumulated throughout the nation extensive data that should be given intimate and close study by your committee and interpreted in the light of Wisconsin needs. Your committee and, through your committee, the members of the Society throughout Wisconsin should have the benefit of the knowledge that will be derived from the American Medical Association's special department in this field.

APPENDIX

THE STATE MEDICAL SOCIETY OF WISCONSIN

Madison, July 23, 1942

Mr. J. F. Machotka, Chief
Community and Cooperative Services
Farm Security Administration
Milwaukee, Wisconsin

Dear Mr. Machotka: I am submitting with this letter the trial plan for voluntary sickness insurance developed by the State Medical Society, through its Committee on Voluntary Sickness Insurance and with the active assistance of members of the Monroe County Medical Society, in connection with the proposal advanced by you and Dr. Boyd as representatives of the Farm Security Administration in Wisconsin for such a sickness plan for certain clients of the Farm Security Administration within various counties of Wisconsin.

If I may be permitted to recapitulate the substance of the meetings of the State Medical Society with representatives of the Farm Security Administration over the past three or four years, I note that as early as the fall of 1937 proposals emanated through your Administration to provide a sickness care plan for clients of that organization residing in Wisconsin. From that time until the late spring of 1939 numerous conferences were held with representatives of your organization to see if some medical care arrangement could be tried and perfected.

We appreciate, of course, that the Farm Security Administration approaches the problem with the viewpoint that as it is a loaning agency it is important that the health of its clients and their families

be maintained in the best manner possible to protect it against the hazards which might affect its loans should ill health enter into the picture. You feel that this may be best accomplished both for the clients and for the physicians if the exact cost of health and sickness care can be determined in advance and made the basis of annual loans or other budget arrangements between the Farm Security Administration and its clients who care to participate in the proposal.

In 1939 we recounted to you the experimental efforts then being undertaken in Douglas County and elsewhere, and gave you full details of our extensive studies of the plans in existence in Wisconsin, elsewhere in the country, as well as in certain European localities. We pointed out to you at that time that certain governing resolutions adopted by our House of Delegates permitted the conducting of these experiments, for the Medical Society could participate as an organization in the then existing trials upon the basis that those who participated as physicians guaranteed that the factors inimical to public health discovered by us as fundamentally inherent to voluntary schemes of insurance would not be permitted to affect the quality or quantity of the sickness care rendered under the experiment.

In May, 1939, my brother, who was then Secretary of the State Medical Society, submitted to you an outline of an agreement which, in his opinion, could be consummated between the Farm Security Administration and the State Medical Society and certain county medical societies in the state, which would assure the high standards of health care that you desire be made available to your clients; which would assure further the basic scheme being in the character indicated by you as desirable, and finally, would offer the assurance of the Farm Security Administration that should the subscriber premiums prove insufficient to pay the physician in full a predetermined percentage of his normal schedule of fees the Farm Security Administration would contribute such additional amounts as would be necessary to permit the full payment for medical services rendered at the allowance agreed upon in advance. It was felt by the State Medical Society at that time that in this fashion the Farm Security Administration and its clients, who are admittedly not of the poor relief classification, would thus assure to the physician their every cooperation that while the physician held himself available at a reduced percentage of his normal schedule of fees that basic amount would be assured him in any event.

Subsequently, representatives of the Farm Security Administration advised that it would be impossible to enter into such a trial plan, and consequently no further steps were taken until the late fall of 1941 when you, in the company of Dr. Boyd and others, revived the basic proposal of the Farm Security Administration. This was the time, you will recall, Mr. Machotka, when an individual interview was conducted by you and your associates with each of the councilors of the State Medical Society, and I believe it was also just following the occasion when you had personally canvassed the Farm Security clients in Monroe County to ascertain the extent of their interest and cooperation.

In January of this year, after your appearance before it, the Council of the State Medical Society authorized the Committee on Voluntary Sickness Insurance to again examine into the proposal advanced by the Administration which you represent, and you will recall the several conferences had with you and other representatives of your organization at Beaver Dam and at our offices with respect to the matter. Following these conferences, in which your thoughts were re-explained, the Committee on Voluntary Sickness Insurance met on numerous occasions in its studies of your proposal and in its effort to provide the basic structure which would at once assure the protection of patient health and yet meet the thoughts advanced by you and your associates. The proposal as it is now prepared is attached to this letter. It has been explained in detail before members of the county medical society which you desire to interest in the subject. It has been considered both by the Committee on Voluntary Sickness Insurance and by the Council of the State Medical Society and now is given to you as their final thought on the subject.

In that plan you will note that while the basic premium schedule suggested by your Administration is followed, nevertheless to protect the physicians against the hazards of a contribution in excess of that contemplated when they agree to fees at a sum considerably less than that normally charged in the community, the Farm Security Administration would be committed to make an initial loan in an amount in excess of the premium suggested by yourself, the difference between the suggested premium and the loan to be held apart as a special reserve for the financial contingencies of the plan.

I do not feel it necessary in this letter to enter into a detailed explanation of the mechanics of the plan. If in its basic form it meets the approval of your organization the additional documents that would need to be drawn to put it into operation could be prepared speedily, and the full cooperation of the county medical society and of the State Medical Society would be available to assure a genuine experiment in your proposal of voluntary sickness insurance, an experiment that would embrace certain features not now a part of other experimental plans in other parts of the country nor a part of any experimental plan heretofore conducted by the State Medical Society.

Should the plan be placed in effect, I can offer my assurance in behalf of the doctors participating that adequate medical care of a quality beyond dispute would be available.

We hope that the proposal attached made on behalf of the State Medical Society of Wisconsin will prove to be one that your Administration can see fit to approve in the light of present-day conditions. I look forward to the further opportunity of co-

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Yours very sincerely,

C. H. CROWNHART
Secretary

Medical Care Plan For Farm Security Administration Standard Loan Families in Monroe County, Wisconsin

Introduction; Principles.—In continuance of the established policy of experimentation and research of the State Medical Society of Wisconsin and its component county medical societies, the State Medical Society and the Monroe County Medical Society, of Monroe County, Wisconsin, agree in the manner outlined in the following paragraphs of this Medical Care Plan to provide medical care for persons indebted to the Farm Security Administration as standard loan borrowers. The State Medical Society of Wisconsin has, in prior years, engaged in other voluntary sickness insurance plans, and declares its willingness to assist in this further experimentation as an additional contribution to its studies and research, because of its ever continuing interest in the public health.

It is asserted that standard loan borrowers of the Farm Security Administration constitute a part of the so-called "low income group" and that while they do not fall into the relief category, neither can they be considered as in the wholly self-sustaining group, by reason of their low, or even marginal, incomes. It is on this basis that the Farm Security Administration has asked that this medical care plan be conducted, and it is in acknowledgment of the economic group status of standard loan borrowers that the State Medical Society of Wisconsin and the Monroe County Medical Society are willing to undertake this group medical care experiment, and to make the substantial contributions in medical administration and medical care which are later set out in this Plan.

The Monroe County Medical Society, together with the State Medical Society of Wisconsin, under the provisions of section 148.01 (3), Wisconsin Statutes, and at the request of the Farm Security Administration, joins with that governmental agency in establishing as a trial or experimental program for voluntary sickness insurance, a plan which shall embrace the following principles:

1. Medical care rendered under this Plan shall be limited to standard loan borrowers of the Farm Security Administration, and those borrowers who subscribe to the Plan shall be entitled to free choice among the physicians participating herein, subject to the contingency of military service.
2. The confidential physician–patient relationship shall be maintained in so far as possible.
3. Participation under the Plan shall be voluntary on the part of both physicians and standard loan borrowers of the Farm Security Administration.
4. The physician may accept or reject patients in accordance with his professional judgment.
5. The amount to be prepaid as the annual premium by each subscriber to this Plan is declared to be reasonable and within each such subscriber's ability to pay.
6. Funds are to be deposited with and disbursed by a mutually approved trustee.
7. Statements for services rendered by participating physicians shall be reviewed and approved by a Medical Service Committee of three (3) physicians selected from the membership of the Monroe County Medical Society.

Medical Service Committee.—The Medical Service Committee consisting of three members selected from the membership of the Monroe County Medical Society is intended to coordinate and administer the professional medical aspects of this Plan and is vested with the full powers necessary to that end. This committee shall have the power to:

1. Distribute application blanks which will be furnished by the Society in the form set forth in Exhibit "A" to those who indicate their desire to become subscribers.
2. Pass upon all applications for subscription membership, and questions of acceptance or rejection shall rest solely with it.
3. Issue to and maintain for each subscriber, a subscription card similar to that set forth in Exhibit "B."
4. Obtain information and maintain records showing subscribers' eligibility for medical care under the terms of this Plan.
5. Establish a schedule of fees upon which payment to participating physicians for services rendered to subscribers shall be determined. Such schedule shall be based on the minimum customary charges made in private practice in Monroe County for patients of similar income levels, further reduced by 25 per cent.
6. Prepare and maintain a panel of physicians who have indicated their willingness to participate in the trial, and from among whom subscribers shall have free choice in the manner specified herein. Physicians upon the panel may withdraw or be withdrawn therefrom (after a full hearing) upon such conditions and regulations as may be established therefor by the Committee. Such powers shall be subject at all times to control of all participating physicians (by majority vote of those present at a meeting for that purpose) upon reference thereto by either the participating physician or the Medical Service Committee.
7. Verify subscription status of subscribers for panel physicians.
8. Receive funds under the terms hereof, and have them placed in trust fund accounts.
9. Receive, audit and prepare for payment all vouchers from participating and consulting physicians.
10. Receive, audit and approve for payment, extra-territorial cash benefits to subscribers who received, while outside Monroe County, emergency medical care of a character approved by the Committee.
11. Maintain ledger accounts showing the amount of service rendered by each participating physician, the amount paid each participating physician, and the balance due each such physician.
12. Record all statistical data from the vouchers submitted by panel physicians and from application form of subscriber, including such as may be required by the State Medical Society of Wisconsin. For this purpose, and to permit proper billing by attendant physician, permission to view subscribers' medical records is extended. Such medical records are available only to officials of the State Medical or Monroe County Medical Societies, and the Medical Service Committee, and for such purposes only.
13. Formulate and prescribe such rules as it may deem necessary to effectuate the purposes of this Plan.

Conference Committee.—There shall be established a Conference Committee to help assure the satisfactory operation of this trial Plan. The Con-

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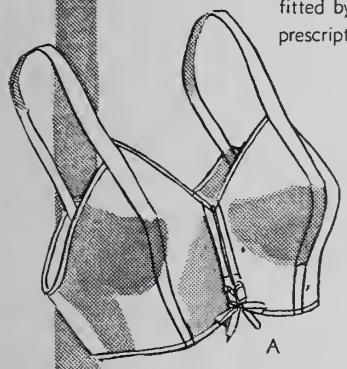
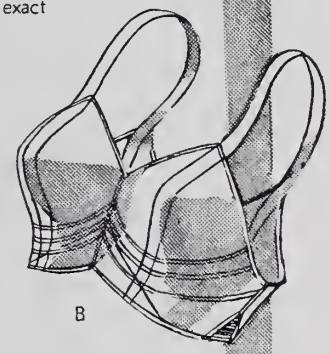


A

MATERNITY AND NURSING MODEL

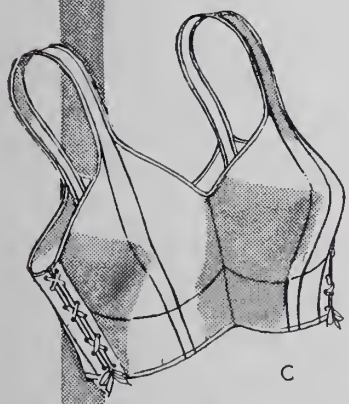
A. Allows free circulation and drainage during pregnancy and lactation. Adjusted, each month, without charge, during the pre-natal period.



B

DEVELOPING GIRL MODEL

B. Designed to promote normal development with perfect freedom for growing glands and tissues. Sizes for girls as young as ten or twelve.



C

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C. Provides for recuperative shortening of stretched blood vessels and fascia to relieve strain of unsupported tissues on tension during sleeping hours.

D

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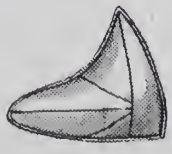

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ference Committee shall be composed of the Medical Service Committee and three representatives of Farm Security Administration standard loan borrowers subscribing to the Plan. One representative of the State Medical Society of Wisconsin shall serve as an ex-officio member of the Committee.

Eligibility to Participate in Plan.—All standard loan borrowers of the Farm Security Administration having legal settlement in Monroe County, Wisconsin, may apply for participation in the Plan on the application form designated as Exhibit "A."

The term "standard loan borrowers" is defined to be those persons who have obtained a five-year rural rehabilitation loan from the Farm Security Administration, as more particularly defined in FSA Instruction 731.1, dated October 25, 1938; provided, further, that the medical care provided under this Plan shall likewise be available to the wife and minor children of each subscriber and to such subscriber's parents, or to such of said persons as regularly and permanently make their home with the subscriber.

The term "subscriber" shall mean a standard loan borrower whose application to participate in this Plan has been accepted by the Medical Service Committee.

Applicants shall submit such information as shall be deemed proper to make a correct evaluation of the trial Plan. In submitting his application the applicant shall authorize the physician or physicians from whom he obtains care under this Plan to supply such information as shall be deemed essential to the proper review of the statements for services rendered under this agreement and for the gathering of such statistical data as may be needed for evaluating this Plan.

This Plan shall embrace no groups or classifications of the Farm Security Administration other than standard loan borrowers. No application shall take effect unless accompanied by the premium hereinafter provided, nor until said application has been accepted by the Medical Service Committee and evidence of such acceptance given by mailing to the applicant a subscription card similar to that set forth in Exhibit "B."

Services to be Included.—Subscribers and covered members of their families shall be eligible under this Plan to receive the professional services generally rendered by physicians and surgeons of Monroe County. This Plan contemplates only the furnishing of the skill and knowledge of the physician. As a condition precedent to the granting of benefits, subscribers agree that consultation shall be obtained from among a group of consultants selected by the participating physicians.

Any participating physician is eligible to be a consulting physician, it being intended, so far as possible, that the services rendered under this Plan be those ordinarily available within Monroe County. The Medical Service Committee shall determine the manner in which cases shall be referred by a participating physician to a consulting physician.

Services Excluded.—In general, this Plan shall exclude hospital care and diagnostic facilities, medicine, drugs, biological preparations and medical supplies. Medical care in obstetrical cases is included only where the subscriber at the time of making application shall have paid an additional annual premium of $10.00 to cover such benefits. Without attempting full enumeration, the services covered by this Plan shall *not* include:

Glass frames and lenses

Drugs, medicines and prescriptions, serums, vaccines and biologicals

Radium and x-ray therapy

Any hospital care, services or charges whatever, other than medical care to which a subscriber or eligible dependent is otherwise entitled and which he is to receive by the terms hereof

Dental care

Appliances and trusses

Care of nervous and mental illness after being so diagnosed by a participating physician or consultant

Treatment of persons suffering from tuberculosis or venereal disease, except that treatment of gonorrhea in a newborn child shall be considered as a service to be included under this agreement rather than as an exclusion

Treatment of drug or alcoholic addiction in persons who have been so diagnosed by a participating physician or consultant hereunder

Highly specialized services not available through participating physicians or consultants designated by them

Medical services to which the subscriber is entitled under the Wisconsin or Federal compensation acts, or for which the subscriber is reimbursed or otherwise receives monetary benefits, payment or indemnity, through group or personal insurance

Extra-Territorial Cash Benefits.—In the event a subscriber while outside the territorial limits of Monroe County, suffers illness of an emergency character and is not able to avail himself of the services of a participating physician, the subscriber shall be eligible for reimbursement in the following manner: The subscriber shall submit to the Medical Service Committee, a receipted, itemized statement of the services rendered by the non-participating physician. The Medical Service Committee may require evidence that such treating physician is licensed to practice medicine and surgery in the area in which he treated the subscriber. Remittance shall be made to the subscriber and not to the physician who rendered the service, and shall be in the same ratio, in similar amount, and at the same time as the current remittance to participating physicians, after the charges have been adjusted to conform with the Monroe County Medical Society fee schedule, earlier referred to herein.

Annual Premiums by Subscribers.—Each subscriber under this Plan who has been certified by the Farm Security Administrator for Monroe County, Wisconsin, as a standard loan borrower shall submit with his signed application for participation herein, the sum of $34.00 as his advance annual premium, plus the further sum of $10.00 in the event he desires obstetrical benefits. Of this sum, $22.00 shall be placed by the trustee in what shall be termed the "Operating Fund;" $1.00 shall be placed in an "Administration Fund" for compensation of the trustee; and the remaining $11.00 shall be placed in escrow in what is termed the "Reserve Fund."

If at the close of the twelve months during which this Plan is intended to operate, or any earlier period in the event the Plan should be sooner terminated for any reason, the participating and consulting physicians hereunder, together with subscribers entitled to extra-territorial benefits, shall have received from the Operating Fund the amount of the statements submitted by them as audited by the Medical Service Committee, and as adjusted to con-

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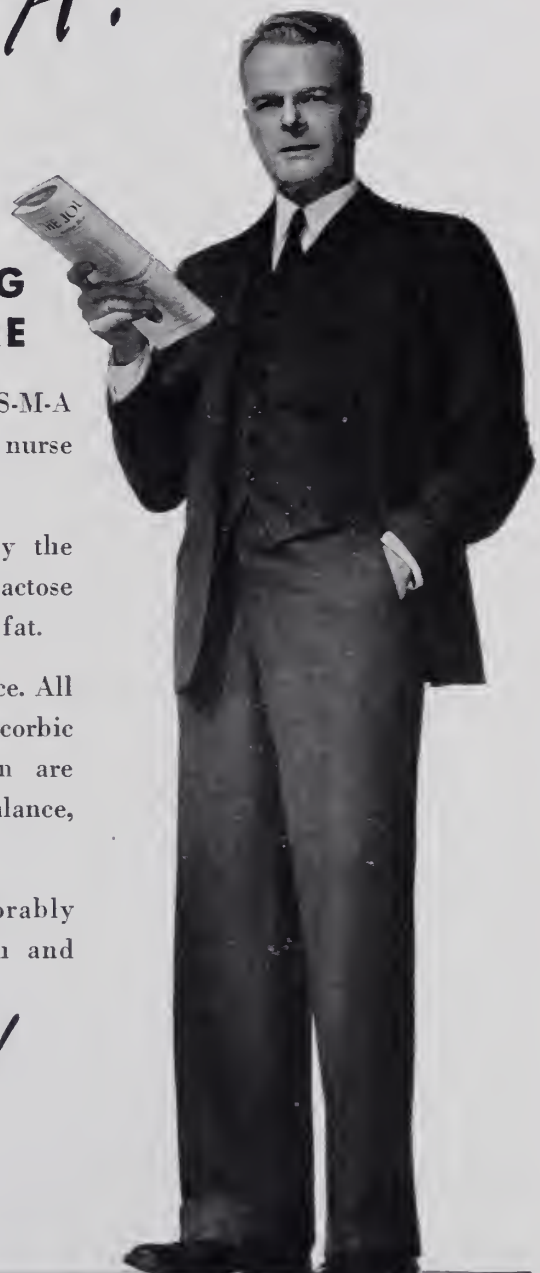

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form with the fee schedule as provided earlier herein under the heading "Medical Service Committee," and which shall be controlling on the parties hereto, the entire amount of $11.00 per subscriber deposited in the Reserve Fund as above provided shall thereupon be refunded to each subscriber; provided that if the subscriber's Farm Security Administration loan for prepayment of the premium of this Plan shall not then have been repaid, such refund may, on the written request of the Farm Security Administration, be paid directly to the latter to be credited to such subscriber.

If the Operating Fund shall have been insufficient to permit full payment of the professional statements rendered by participating physicians after being audited and adjusted as above provided, such portion of the Reserve Fund shall be transferred to the Operating Fund by the trustee as may be necessary to pay the full balances due the participating physicians, consultants and subscribers entitled to extra-territorial cash benefits, as shown by the statements after being audited, adjusted, and allowed.

If the total of audited and adjusted statements submitted by participating physicians, together with consultation fees and extra-territorial cash benefits to subscribers, shall exceed the advance premiums of $33.00 a family, thus including the full Reserve Fund, prorata payments shall be made to all three groups as far as the funds will permit, and the physicians shall accept in full payment such funds as are available.

The sum of $1.00 per subscriber deposited in the "Administration Fund" shall be paid to the trustee as his full compensation for keeping the necessary records, preparing and mailing checks, handling funds, and for the premium on his bond.

The Medical Service Committee shall not be compensated in any way for the performance of its medical administrative duties heretofore enumerated in that portion of the Plan entitled "Medical Service Committee," it being the desire of the medical profession that these administrative services be wholly donated to assist in the conduct of this experimental plan. Such medical administration, although both extensive and essential, is therefore not within the premium structure of the Plan.

No compensation or reimbursement shall be provided from the premium for the solicitation or other services furnished by any Farm Security Administration agent, nor for any transportation or other expenses of any character, incurred in connection with such solicitation of subscription agreements.

Participation in Plan.—To become eligible for benefits, each subscriber under this Plan must first have been certified by the Farm Security Administrator for Monroe County, Wisconsin, as a standard loan borrower, and must submit his signed application and the sum of $34.00 (plus $10.00 additional in the event he desires obstetrical benefits) as his prepaid annual premium, and must have his application accepted by the Medical Service Committee.

Each subscriber will receive an identification card indicating the dependents eligible for care under the Plan in addition to himself. The Plan will become operative 15 days after the Farm Security Administrator from Monroe County has certified in writing to the trustee that each subscriber whose application has been accepted by the Medical Service Committee has legal settlement in Monroe County, Wisconsin; that he is a standard loan borrower of the Farm Security Administration; and that the applications accepted aggregate not less than 90 per cent of all standard loan borrowers in Monroe County. The trustee shall notify the Medical Service Committee on receipt of such certification of the date on which the Plan is to become operative, and shall further advise the Medical Service Committee that the advance premium of each accepted subscriber has been received and deposited.

Trustee.—The Conference Committee shall select by majority vote a trustee to receive all the prepaid premiums and to make all disbursements under this Plan. Out of each $34.00 paid by an annual subscriber to the Plan, $22.00 shall be deposited in the Operating Fund. There shall also be deposited therein the entire $10.00 paid as an additional premium by those desiring obstetrical benefits. The sum of $1.00 shall be deposited in the Administration Fund as full compensation to the trustee, and one-fourth of the amount so deposited shall be payable to him at the end of each quarter. The remaining $11.00 of the prepaid annual premium shall be deposited in the Reserve Fund, and shall be refunded in full to the subscribers after the termination of this Plan unless needed for the purposes earlier set out herein under the heading "Annual Premiums by Subscribers."

Payments from either the Operating Fund or the Reserve Fund shall be made only upon the presentation of vouchers approved by the Medical Service Committee.

The trustee shall have authority to recover from a subscriber the amount of medical benefits paid hereunder for him or his dependents where mistakenly, fraudulently or otherwise, it is subsequently found that such services should not have been paid by the trustee out of funds created for the operation of this Plan.

In cases in which a third party is responsible for, or assumes payment of medical services rendered a subscriber hereunder, neither fund provided for in this Plan shall be liable for the payment of such physician's services. A physician who has secured payment from a third party shall rebate to the trustee the amount of any services for which he has also been paid under this Plan.

The trustee shall be bonded in the amount of $_____, the costs thereof to be borne by the trustee.

Payments For Medical Care.—*Introductory.* Payment to physicians participating in this Plan, and to the consultants chosen by such physicians, is predicated on the assumption that those who shall be subscribers under this Plan are neither in the wholly self-sustaining nor in the relief classification, but are for the most part to be regarded as between the two groups. The Monroe County Medical Society accepts this as an accurate analysis of the abilities of the families to pay for needed medical care, and is willing, in recognition of the situation, to make the following contributions to this experimental effort:

1. Professional charges based upon minimum, rather than customary or maximum fees.
2. Further voluntary reduction of such minimum fees by 25 per cent.
3. Willingness, in the event funds are insufficient to pay for services on the above reduced basis, to accept a pro-rata part of the remaining available funds in full payment of all of the then remaining unpaid balance due for professional services rendered under the Plan.
4. Medical administration services which will be necessary before the Plan can be in operation, which must continue throughout its operation and which will be essential to an objective evaluation of the Plan after its termination.

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The profession, however, feels that to call upon them for any additional contribution would do an injustice to the experimental nature of the Plan, because it would, in effect, postulate both its operation and success on a subsidy made up of a "professional service guaranty pool."

Monthly Statements. In order to facilitate the medical administration of this Plan, and so as to permit the making of necessary inquiries and adjustments with a minimum lapse of time, each participating or consulting physician, although he will be compensated only quarterly, shall submit to the Medical Service Committee a professional statement billed at the charges shown in the minimum fee schedule for each month in which he rendered services to subscribers under this Plan, such statement to be sent to the said Committee not later than the tenth of the month following that in which the services were rendered.

Each such statement shall first be audited by the Medical Service Committee, and when approved shall then be reduced by 25 per cent in accordance with earlier provisions of this Plan headed "Annual Premiums by Subscribers."

Quarterly Payments. The funds from all subscribers shall be set aside in quarterly amounts in the Operating Fund and designated as available for the payment of medical services rendered during that quarter. Statements which have been forwarded to the Medical Service Committee during a quarter by a participating physician, by a consultant designated by such physician, or by a subscriber showing payment to a physician who has rendered extra-territorial services of a character included in this Plan, after being audited, adjusted and approved by the Committee, shall be totaled for the quarter and payment made by the Trustee on a prorata basis of the amounts shown on the Committee vouchers.

In the event funds available at the termination of the fourth quarter are not sufficient to permit payment to physicians of the full amount of the year's statements under the agreed fee schedule for Monroe County, the Medical Service Committee shall thereupon instruct the trustee to withdraw such portions of the Reserve Fund as may be necessary (or all of said Fund if needed) to permit payment of extra-territorial cash benefits to subscribers, and payments to participating physicians and to their consultants to the extent of their audited and adjusted statements. In the event prorata payments have to be made because the balance in both the Operating and Reserve Funds is insufficient to pay such professional statements, there shall be no resulting liability either as to the Monroe County Medical Society, the State Medical Society, or the Farm Security Administration for any unpaid balance.

Participating Contract: Subscriber's Contract.—Each participating physician shall come into this Plan through a Participating Contract which he executes separately with the Monroe County Medical Society. Each eligible subscriber shall come into this Plan through his Application and Subscriber Contract, which he shall execute separately with the supervisor of the Farm Security Administration and the chairman of the Medical Service Committee. Each of these contracts, which is in reality nothing more than an extension of this Plan and is separate from it only for reasons of convenience and administration, is deemed incorporated into this Plan, and this Plan into it, as if fully set out.

Plan Operative One Year.—This Plan shall remain in operation for twelve months from its effective date, and shall automatically terminate at the end of that time.

Analysis; Statistical Studies; Releases.—All parties to the agreement recognize that the successful conduct of this experiment is dependent upon the cooperation of each of the participating groups or agencies. Each participant to the agreement recognizes further that the conduct of the experiment can be imperiled by premature and individual releases, findings, studies and comments, and each party agrees to refrain from making independent findings, studies, comments and releases, and shall direct its efforts to the preparation of joint materials of that character, which materials and findings may be given full publicity after the termination of this Plan.

It is expressly agreed by the parties that neither the Monroe County Medical Society, the State Medical Society of Wisconsin, nor the Farm Security Administration, is to be considered as in any way the guarantor of either the quality or quantity of professional services to be rendered hereunder, nor does any of the parties in any way assume any liability whatever for any act of any participating physician, consulting physician, or subscriber borrower of the Farm Security Administration.

It is expressly understood that the principals hereto are limited in their functions to arranging, in complete good faith, this Plan for bringing together physician facilities of the area in question, and a designated population group alleged to have special need of such services.

Executed in quadruplicate, this _____ day of _____, 1942.

_____
President, Monroe County Medical Society

_____
Secretary, Monroe County Medical Society

_____
J. F. Machotka, *Regional Health Specialist, Farm Security Administration*

_____
R. R. Supervisor, Farm Security Administration, Monroe County, Wisconsin

Approved:

_____
C. H. Crownhart, Secretary
State Medical Society of Wisconsin

Application and Subscriber Contract—Monroe County Medical Society—Farm Security Administration Medical Care Plan

I. Application.—(To be drafted later, after determining how complete a medical background to be included. Show carefully ages and number of dependents to be covered and whether obstetrical care desired. Also show amount enclosed and whether obstetrical care included.)

II. Subscriber Contract.—The applicant further agrees to be bound by the terms of the Medical Care Plan entered into on the _____ of _____, 1942, by the Monroe County Medical Society, the Farm Security Administration, and the State Medical Society of Wisconsin, a copy of such Plan having been made available to the undersigned. Summarized below for the applicant's convenience are certain of the provisions of the Plan having direct application to him:

1. *Free Choice of Physician.* The applicant is to have free choice among the Monroe County physicians participating in the Plan, subject to the contingency of military service, a list of said physicians to be made available to the applicant at the time his application is accepted, and shall also have free choice among medical consultants recommended by a participating physician.

2. *Medical Cash Benefits Outside County.* The undersigned shall be entitled to cash benefits by way of reimbursement for medical services rendered during illness of an emergency character while he, or any member of his family covered by this agreement, were outside the limits of Monroe County, Wisconsin. The undersigned understands that he will not be entitled to any cash benefits for medical services rendered either to him or to any of his covered dependents outside the limits of Monroe County unless they are of an emergency character; and that a receipted statement for any medical services which have been rendered to him or covered dependents for which he may seek reimbursement under this Plan shall first be subject to the same fee schedule and adjustment as are the professional statements of participating physicians, and may be further reduced in the event funds in the hands of the trustee are insufficient to pay the full amount of such statement after adjusted.

3. *Prepaid Annual Medical Premium.* The undersigned encloses with this Application the sum of $34.00 (together with an additional $10.00 if obstetrical care is desired) which it is understood will cover for an entire year the professional services generally rendered by physicians and surgeons of Monroe County, Wisconsin, it being further understood that in the event the entire prepaid annual premium should not be required, the undersigned will be entitled to a refund of such portion of the premium up to $11.00, as shall be unexpended at the close of the year for which this Plan is to be in operation.

4. *Summary of Benefits.* The undersigned understands that this Plan *includes* only the furnishing of the knowledge and skill of the physician and that it *excludes:* all hospital care, treatment and facilities except medical care provided by the Plan which may be given while the applicant is in a hospital, medicine, drugs, biological preparations, medical supplies, dental care, and such forms of highly specialized care and treatment as are necessary in cases of mental and nervous diseases, tuberculosis, venereal diseases (except gonorrhea in a newborn child), drug or alcoholic addiction, or those services not available through participating physicians or the consultants designated by them. Obstetrical care is likewise excluded unless the undersigned elects at the time of making this Application to take those medical benefits by the payment of an additional $10.00.

5. *Partial Waiver Medical Privilege.* The undersigned hereby waives his statutory physician–patient privilege to the extent necessary for billing, for the gathering of statistical, medical and other data, and for any other purposes related to the performance of the said Medical Care Plan, dated _____, 1942.

In making this Application the undersigned understands and expressly acknowledges that the Farm Security Administration and the Monroe County Medical Society are entering upon a voluntary trial of an experimental method of securing and paying for medical care which does not change the freedom of the undersigned to engage the physician of his selection, so long as he is a par-

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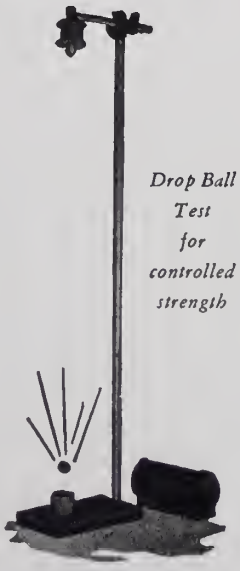

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ticipant in the Plan, and which in no way changes the contract and tort relationships which would exist were the undersigned to retain such physician by ordinary arrangements made outside this voluntary Plan. It is understood that a physician shall automatically be considered as no longer participating in the Plan as of the date of his induction into military service or into the Public Health Service of the United States Government. The services available, and the conditions under and extent to which available are set out in detail in the said Plan. The contents of that Plan have been explained to the undersigned by a representative of the Farm Security Administration, and upon acceptance of this Application the undersigned understands that he is bound by the terms and provisions of that Plan along with any eligible dependents on whose behalf this Application is likewise made. The undersigned further understands that the Farm Security Administration and the Monroe County Medical Society have acted only to fix the limits of this experimental plan and to arrange the technical and other details through which medical services may be made available to the undersigned and to his dependents at a reasonable prepaid annual cost, and that neither the Monroe County Medical Society, the Farm Security Administration, nor the State Medical Society of Wisconsin, is agreeing, as such, to furnish the undersigned with medical care or in any way to guarantee its quality or success.

6. *Certification of Eligibility.* The undersigned certifies that he is a standard loan borrower of the Farm Security Administration; that he has legal settlement within the territorial limits of Monroe County, Wisconsin, and that all the statements made in Part A of this Application are true so far as he knows or has reason to believe.

_____
Applicant and Subscriber

Witnessed by:

_____ of _____

_____ of _____

Approved by:

_____
R. R. Supervisor, Farm Security Administration, Monroe County, Wisconsin

_____
Chairman, Medical Service Committee Monroe County Medical Society

Physicians Participating Contract—Medical Care Plan—Monroe County, Wisconsin, Medical Society

The undersigned, a member of the Monroe County Medical Society, a component of the State Medical Society of Wisconsin, is aware of and has participated in the action of the said societies in the preparation and drafting of a Medical Care Plan for Farm Security Administration standard loan borrowers residing in Monroe County, Wisconsin, a copy of said Plan having been made available and explained to the undersigned.

That Plan, having been duly executed by the officers of the Monroe County Medical Society, as of the _____ day of _____, 1942, and having been approved by the State Medical Society, I desire and by this Contract agree that my name appear on the panel provided by the voluntary Plan above referred to, and do further agree that I shall be available for professional services to the subscribers to said Plan in accordance with its terms and provisions, and to the fullest extent of my professional ability, it being my understanding that I am free to exercise my professional judgment in accepting or rejecting as a patient any subscriber or eligible dependent of such subscriber who may seek my professional services. In the performance of my duties under such Plan, I agree to render full and adequate professional services without discrimination of any kind and to lend my wholehearted cooperation to the success of the Plan, and do further agree that my continuation in good standing in the Monroe County Medical Society shall be a condition of my continuing on this panel.

Not later than the 10th of the month following a month in which I render professional services to a subscriber to the Plan, I agree to submit to the Medical Service Committee a statement of services rendered under the Plan to be billed in accordance with the special Fee Schedule which is a part of this Contract, and of which I have a copy. I understand that the Medical Service Committee has full authority under the Plan to audit any statements for professional services which I submit under the Plan, and after auditing and approving such statement, to reduce it by an additional 25 per cent. In the event funds are insufficient to permit payment in full of my statements after audited and adjusted by the Committee, I also agree to accept in full settlement, an amount equal to 90 per cent of statements which I submit under the Plan after they have been audited and adjusted by the Committee, or to accept any lesser percentage on a prorata basis with other physicians, should funds be insufficient to pay as much as 90 per cent. I agree that in no event shall I look to the patient, the Monroe County Medical Society, the State Medical Society of Wisconsin, or to the Farm Security Administration, for any further or other compensation in connection with professional services rendered under said Plan.

I understand that a prorata payment will be made to me on a quarterly basis, and that any deficit which may develop during the term of the Plan, by which is meant any difference between what is paid and an amount equal to the audited and adjusted fees approved by the Medical Service Committee will be remitted to me as soon as possible after the termination of the Plan to the extent of funds available for that purpose, subject to the contingency that funds may be insufficient to pay all or any part of the final deficit which may remain after the termination of the Plan.

I acknowledge that I now carry physicians' malpractice liability insurance, and that I shall continue such insurance in force throughout the term of the Plan. (*N. B.*—It may be well to omit this because of difficulties of so many of the physicians in getting such coverage now. A comparable provision did appear in a former county plan, however.)

I also agree to limit my consultants to other participating physicians under the Plan, unless authorized in writing by the Medical Service Committee to do otherwise.

Dated: _____, 1942.

_____ *M. D.*

Approved and filed _____, 1942.

_____
Monroe County Medical Society

CORRESPONDENCE

July 13, 1942

Mr. C. H. Crownhart, Secretary
The State Medical Society
Madison, Wisconsin
Dear Mr. Crownhart:

Not until yesterday did I have an opportunity to look at the very fine supplement of *The Wisconsin Medical Journal* containing the articles on "The nutritive value of Wisconsin farm and dairy products." These articles are indeed very high-class. Mrs. Witte, to whom I showed the issue, thought so highly of these articles that she is keeping them for future reference.

Appreciating your initiative in this manner and with every good wish, I am

Sincerely,
EDWIN E. WITTE
Department of Economics
The University of Wisconsin

August 12, 1942

Mr. C. H. Crownhart
Secretary
The State Medical Society
Madison, Wisconsin
My dear Mr. Crownhart:

Your letter to Mr. Callahan of June 20 has finally reached my desk.

Our supervising teachers and county superintendents have been asked to pay special attention this year to school lunches. If you can spare them, I think it would be a fine idea to have a copy of this reprint ("Health and Food" supplement to June issue of *The Journal*) for each of our county school lunch committee chairmen. That would make about one hundred copies if we can also give a few to the members of this department.

Thanking you very much for the information, I remain

Very sincerely yours,
MAYBELL G. BUSH
Supervisor of Elementary Schools
The State of Wisconsin
Department of Public Instruction

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News Items and Personals

Dr. Harold H. Oberfeld, Milwaukee, gave a talk on "Watch Your Poisons" at the Grant park clubhouse following the Kiwanis luncheon on July 27.

—△—

According to an announcement made by Mr. Basil O'Connor, president of the National Foundation for Infantile Paralysis, Incorporated, a grant of $1,500 was made on August 6 to the Marquette University School of Medicine, Milwaukee, to carry on research work in the fight against infantile paralysis.

The purpose of the grant is to study the relationship of nutrition to the morphology and physiology of the neuromuscular apparatus in skeletal muscle.

The funds which make possible the Foundation's programs are raised annually in January during the various celebrations of the President's birthday.

—△—

Lieutenant Robert T. McCarty, USNR, a graduate of the Marquette University School of Medicine, Milwaukee, in 1931, who has been serving as medical officer at the Naval Training School, Wahpeton, North Dakota, has received orders to proceed to the west coast to assume a new assignment.

Lieutenant McCarty practiced at Appleton until he entered the Naval service three months ago. He is a member of the board of trustees of the Riverview Sanatorium at Kaukauna and the Marquette University Alumni Association. He was commander of the Lake Winnebago squadron of the Coast Guard auxiliary.

At Wahpeton he set up the sick bay for the training school for machinists' mates on the State School for Science campus, established two months ago.

Dr. Henry H. Christofferson, Colby, was re-elected president of the State Board of Medical Examiners at the Board's meeting in Milwaukee during the week of July 13.

—△—

Dr. Eben J. Carey, dean of the Marquette University School of Medicine, addressed the American Legion Auxiliary state convention in Milwaukee on August 2. His talk emphasized the importance of the physical and mental health of the youth of today as a factor governing the stability of future democracy.

—△—

On August 12, *Dr. Frank M. Scheele*, Waukesha, was named health commissioner of Waukesha. He succeeds *Dr. Paul Campbell* who has enlisted in the Navy. Dr. Campbell, appointed for two years last May, was granted a leave as health commissioner until the expiration of his term. *Dr. Gwylym Davies* was named deputy health commissioner.

—△—

Dr. Carl O. Schaefer, Racine, was elected a Governor of the American College of Chest Physicians at the annual meeting of the College held at Atlantic City, June 6–8.

—△—

Cedar Grove's two veteran doctors, *Dr. Louis A. Van Altena* and *Dr. Anthony Voskuil*, were honored by their patients and friends at an "appreciation picnic" in Cedar Grove on July 25. The former took up his medical practice at Cedar Grove in 1895, while Dr. Voskuil's service in the community dates back to 1909.

A talk was given by *Dr. Gilbert H. Stannard*, representing the Sheboygan County Medical Society.

Society Proceedings

Ninth Councilor District

The summer meeting of the Ninth Councilor District was held July 23 at Wisconsin Rapids. Following dinner at the Paper Inn, Port Edwards, Charles H. Crownhart, Madison, secretary of the State Medical Society, told of the Society's activities in World War II. Theodore A. Brazeau, Wisconsin Rapids attorney, discussed "The Doctor in Court."

Fourth Councilor District

The annual "get-together" of the district was held on August 19 starting with a 6:30 dinner at the Park Hotel, Richland Center. Dr. C. A. Harper, Madison; Dr. Gunnar Gundersen, La Crosse; and Mr. Charles Crownhart, secretary of the State Society, Madison, were present at the meeting.

Colonel Amory A. Miller and Major Norman L. Sheehe of the Medical Officer Recruiting Board, Milwaukee, addressed the group and answered questions on the Procurement and Assignment Service.

SOCIETY RECORDS

New Members

C. P. Haseltine, Ripon.
C. A. Morrow, Viola.
B. A. Ruskin, Wauwatosa.
Ray Rueckert, Madison.
T. C. Erickson, Madison.
H. A. Dickie, Madison.

(Continued on page 862)

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FRACTURES & TRAUMATIC SURGERY—Two weeks intensive course will be offered starting September 21st. Informal Course available every week.

GYNECOLOGY—Two Weeks Intensive Course will be offered starting October 5th. Clinical and Diagnostic Courses every week.

OBSTETRICS—Two weeks intensive course will be offered starting September 21st. Informal Course every week.

OTOLARYNGOLOGY—Two weeks intensive course will be offered starting September 14th. Clinical and special courses every week.

OPHTHALMOLOGY—Two weeks intensive course will be offered starting September 28th. Five weeks course in Refraction Methods starting October 19th. Informal course every week.

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SOCIETY RECORDS

(Continued from page 860)

Changes in Address

E. H. Gramling, Milwaukee, to 645 North Seventy-eighth Street, Wauwatosa.

Helen W. Bane, Beloit, to 121 West Gilman Street, Madison.

Haldor Barnes, Marinette to 709 Washington Street, Manitowoc.

W. J. Kief, St. Cloud, to 3235 North Forty-fourth Street, Milwaukee.

BIRTHS

A daughter to Dr. and Mrs. Wendell Marsden, Madison, on August 18.

A son to Dr. and Mrs. George O. Dunker, Milwaukee, on July 30.

Twin sons, David and Daniel, to Dr. and Mrs. Lester Gallett, Pulaski, on August 5.

A son to Captain and Mrs. Edward A. Birge, Jr., Madison, on July 30.

A son, James Patrick, to Dr. and Mrs. Frank J. Gallagher, La Crosse, on July 18.

A daughter, Alice Christine, to Dr. and Mrs. Cecil R. Gilbertsen, Janesville, on July 20.

MARRIAGES

Dr. Hugh P. Greeley, Madison, and Miss Jane Bennett, Auburn, New York, on August 8 at Washington, D. C.

DEATHS

Dr. Charles H. Hilger, 80, a practicing physician for thirty-seven years, most of that time in Milwaukee, died July 24 at his home, 1834 North Fifty-third street, Milwaukee. Dr. Hilger had retired about a year ago.

Born on a farm at Fussville, Dr. Hilger attended Whitewater Normal School, taught school for some years in Minnesota, and then entered the old Milwaukee Medical School, which later became part of Marquette University. After his graduation in 1904 he opened an office in West Bend, Iowa, later coming to Milwaukee.

Dr. Hilger was a former member of the Marathon County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, two sisters, and two brothers.

Dr. Joseph Charles Baird died at the Sacred Heart Hospital, Eau Claire, August 8 at the age of 58.

He was born in McGregor, Iowa. After graduating from The Hahnemann Medical College and Hospital at Chicago in 1907 he took a special course at the Illinois School of Electro-Therapeutics. He located in Eau Claire in 1909, the first roentgenologist in that section of the state and a pioneer in his chosen profession. He served both the Sacred Heart Hospital at Eau Claire and St. Joseph's Hospital at Chippewa Falls as roentgenologist. Dr. Baird was instructor of anatomy and physiology at Luther Hospital Training School for Nurses from 1910 to 1922, excluding time spent overseas with the armed forces. He was director of the roentgen laboratory at Luther Hospital from its beginning in 1912 until 1923. Before going overseas he was instructor in roentgenology for the army at Cornell University. He worked overseas with the Johns Hopkins unit and the 127th Field Hospital in France.

At the time of his death, Dr. Baird was a member of the State Medical Society of Wisconsin, the American Medical Association, the Radiological Society of North America, Incorporated, the American College of Radiology, and a Diplomate of the American Board of Radiology. He also served as president of the Eau Claire–Dunn–Pepin County Medical Society two times, the last term ending in December, 1941.

He is survived by his widow, his stepmother, and one sister.

Dr. William G. Dana, 72, retired physician who had practiced medicine in Milwaukee for thirty-three years, died August 1 at his home in Milwaukee.

Dr. Dana was born in Sevastopol, Wisconsin, and taught in Milwaukee public schools when a young man. He served in the last World War as a physician.

He is survived by his widow, a sister, and a brother.

Dr. James D. Nicholson, 74, Milltown, died on July 19 in the Frederic hospital after a lengthy illness.

Dr. Nicholson was born in Hamilton, Ontario, Canada. He attended Upper Canada College for one year, then went to Trinity from 1888 to 1891, at which time he came to the United States and completed his medical training at the Denver College

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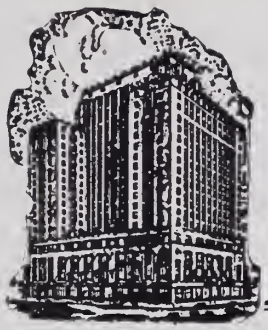

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of Medicine. In 1895 he began practice in Chicago, and in 1900 he moved to Balsam Lake where he conducted his practice for ten years. In 1910 he went to Milltown, where he practiced for twenty-five years.

He was formerly a member of the State Medical Society of Wisconsin and of the American Medical Association.

Dr. Nicholson is survived by his widow and two daughters.

Dr. Fred W. Nause, Sr., 79, Sheboygan, died on August 18 after a lingering illness.

He was born in Sheboygan and was a life-long resident of that city. For three years, as preparation for medical studies, he engaged in a drug business in Chicago. He received his medical training at the Chicago Homeopathic Medical College from where he was graduated in 1887.

He is survived by his widow, one daughter, and a son, Dr. Fred A. Nause, Jr., also of Sheboygan.

Coming Events

State Medical Society

Annual meeting—September 14, 15 and 16 (see program in this issue).

Final Change Made in Plans for 1942 Clinical Congress of the American College of Surgeons

Because the Stevens Hotel, Chicago, has been taken over by the United States Army Air Corps, the thirty-second annual Clinical Congress of the American College of Surgeons, originally scheduled there, will be held in Cleveland from November 17 to 20, with headquarters at the Cleveland Public Auditorium. The twenty-fifth annual Hospital Standardization Conference sponsored by the College will be held simultaneously.

Examinations—American Board of Obstetrics and Gynecology

The next written examination and review of case histories (Part I) for all candidates will be held in various cities of the United States and Canada on Saturday, February 13, 1943 at 2:00 p. m.

Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year. All applications must be in the office of the secretary by November 16, 1942. All candidates will be required to take the Part I examination, which consists of a written examination and the submission of twenty-five case history abstracts, and the Part II examination (oral-clinical and pathologic examination). The Part I examination will be arranged so that the candidate may take it at or near his place of residence, while the Part II examination will be held late in May, 1943, in that city nearest to the largest group of applicants.

Effective this year there will be only one general classification of candidates, all now being required to have been out of medical school not less than eight years, having in that time completed an approved one year general rotating interneship and at least three years of approved special formal training, or its equivalent, in the seven years following the interne year. All candidates must be full citizens of the United States or Canada before being eligible for admission to examinations.

Application blanks may be obtained from the office of the secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburgh, Pennsylvania.

American Congress of Physical Therapy

The American Congress of Physical Therapy will hold its twenty-first annual scientific and clinical session September 9, 10, 11 and 12 at the Hotel William Penn, Pittsburgh, Pennsylvania. All sessions will be open to the members of the regular medical profession and their qualified aides. Information concerning the program may be obtained through the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago, Illinois.

American College of Physicians

The American College of Physicians has announced its twenty-seventh annual session to be held in Philadelphia, April 13 to 16, inclusive, 1943. In order to conserve time and expense, the program will be condensed into four days. Dr. James E. Paullin, Atlanta, president of the American College of Physicians, will have charge of the program of general sessions and lectures. The general management of the session and technical exhibits will be handled by the executive secretary, Mr. E. R. Loveland, 4200 Pine Street, Philadelphia.

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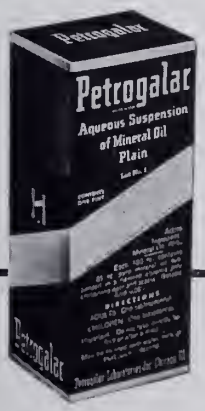

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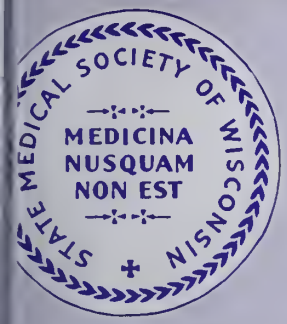

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THE WISCONSIN MEDICAL JOURNAL

Volume 41
Number 10

MADISON, WISCONSIN, OCTOBER, 1942

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[Entered as second class matter, June 30th, 1903, at the Post Office at Milwaukee, Wis., under Act of Congress March 3rd, 1879. Transferred to Madison, Aug. 1st, 1929.]
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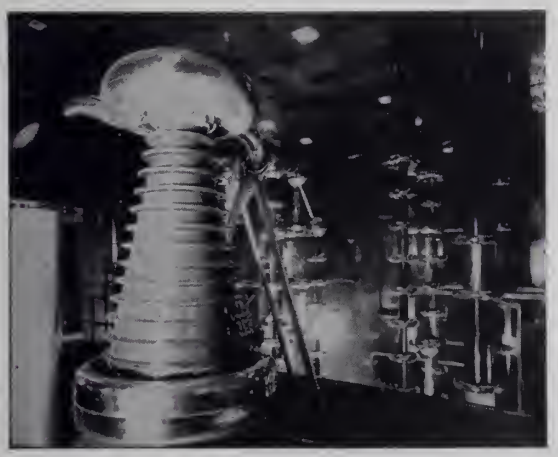

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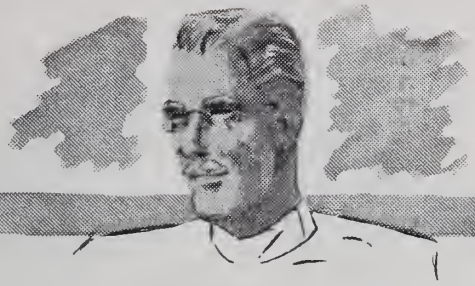

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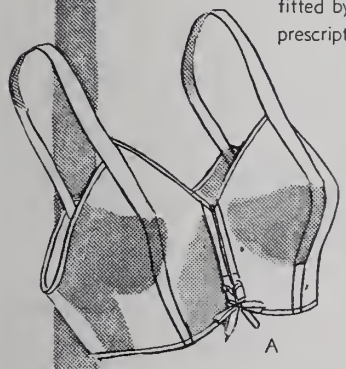

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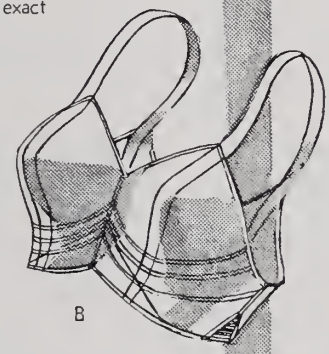

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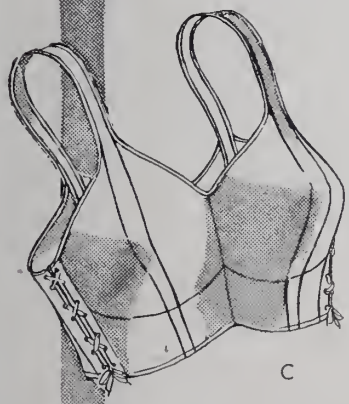

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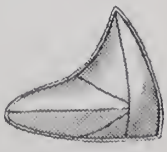

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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
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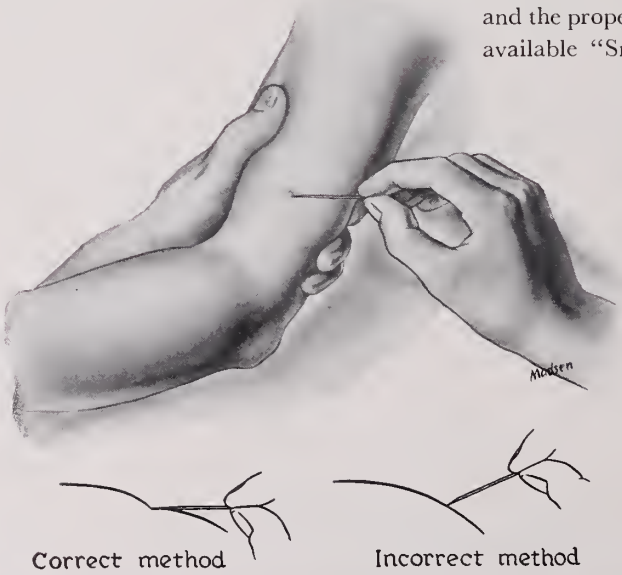
[1]Pub. Health Rep. 57:23,24 (Jan. 2) 1942.
[2]TOOMEY, J. A.: J. A. M. A. 119:18 (May 2) 1942.



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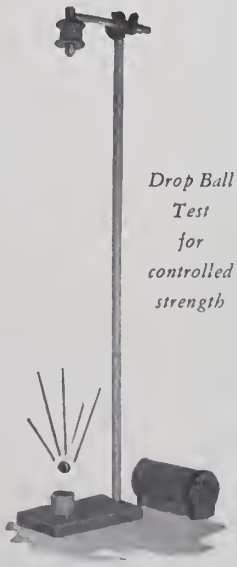

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* N. N. R. 1941, p. 328.

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VOLUME 41, NO. 10 Copyright, 1942, by The State Medical Society of Wisconsin OCTOBER, 1942

A Charge to Keep*

By F. E. BUTLER, M. D.
Menomonie

I APPRECIATE very much the honor conferred upon me in my election as president of this Society. I want to assure you that I am highly desirous of making my year in your service a practical one.

Now that we are congratulating ourselves on having passed into that select group of those who have reached a century of progress; in these times of changing trends in social thought it may be well to take stock and see if the principles laid down by our founders are to be our guide in an effort to furnish our citizens with the best medical service obtainable.

Sickness used to be an episode which concerned the patient, the relatives, and the family physician. Now it has the solicitude and surveillance of the economist, the philanthropist, and the politician.

Radios daily blare forth the necessity of this and that "vitalized" remedy. Papers and magazines expound the merits of one medicine after another. Cults with their laying-on of hands and electric gadgets predict restoration of youthful vigor. Diet faddists herald a fresh hope to the weary with their unscientific combination of food. Now the economists, the philanthropists, and the politicians have taken up the cry.

Evils of Ignorance and Superstition

There is still in the minds of the public at large much superstition regarding sickness and its cure. In early days sickness and pain were regarded as a visitation from an angry god or possession by an evil spirit. These afflicted people rushed terror stricken to the priest, the chief, and the medicine man for prayers, sacrifices, incantations, and fetishes, fully believing that if the proper rite were performed relief would speedily come.

The same spirit is manifested today by those who seek out for treatment the cultists who practice the laying-on of hands and the application and display of mysterious electric appliances and other doodads. It is apparent that we do not have to go back to the dark ages or to the beginning of medicine to find ignorance and superstition.

It is human nature to be complacent about health until there is pain or disability. The sick bed usually is occupied before help is sought. Even then there is a widespread confidence in self-treatment, faith cures, divine healing, and patent medicines. Irresponsibility, ignorance, superstition, stupidity, lack of foresight and thrift are fundamental human defects which no amount of legislation will ever correct with any greater degree of success than prohibition stopped drinking.

If these things are true, there is a dire and crying need, not for more medical care, but for a better understanding of fundamental conditions. There is a tremendous need for public education. Let fear, ignorance, and superstition be banished so that logical and intelligent methods can be applied to the care of the sick and the improvement of the race.

By implication and assertion the medical profession has been placed in a false and defensive position. It has been made to appear that our services are denied to a large number and that much of our skill and therapeutic agencies are rusting from disuse. We are accused of being a closed corporation, smugly withholding our services except to those who can pay. By habit, custom and tradition our profession has carried on its work without ostentation. Hippocrates bound his students to remain silent by

* Presidential address presented at the One Hundred First Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1942.

virtue of the intimate character of their work. Because of this established attitude, which is essentially right, we have until recently left unchallenged this storm of criticism, implication and innuendo.

The public is told that thousands suffer and die from lack of medical care. I need not tell you that the state of health in this country is on a higher plane than at any other time in its history. I need not point out that sickness and death are immeasurably less here than in other countries. I need not affirm that our efforts in preventive medicine have resulted in the control and almost the eradication of certain diseases so that statisticians tell us they will eventually be found only in the pages of history. I need not inform you that the medical profession has completely performed its duty to the needy without reservation or complaint during those unprecedented years of the depression.

Irregular practitioners will find favor with multitudes in preference to physicians as long as ignorance and superstition dwell in the human mind, leaving in their wake tragedy, suffering and incurable diseases. What a paradox it is that doctors of medicine must by law conform to exacting and meticulous standards, while the others, without knowledge, without cultural or scientific training, may practice the healing art with their unscientific and even more ridiculous methods!

The laws of our glorious republic safeguard this wonderful body of ours from the ministrations of the physician, but hand it over with confidence, childlike simplicity, and innocence to the depredations of anyone who calls himself a healer. By any stretch of the imagination is there reason or logic in such solicitude on the one hand and such utter indifference and unrestraint on the other? It will be a blessed day for the public when all who practice the healing art, no matter by what method, are compelled to submit to the same training and conform to the same standards. It should make no difference whether drugs are used, diets offered, or surgery practiced. Ignorance, delay, and improper practices have transformed many curable cases into hopeless invalidism.

I emphasize all this because health insurance takes no cognizance of these evils and their pernicious effects. It is a proven fact that quackery and the use of patent medicines have increased to a startling degree in those countries where this system is practiced. The public, because of general susceptibility to advertising, believes implicitly in a specific cure for all ailments. The patient regards his indigestion as a distinct entity separate from relationship to the rest of his body. With all the impacts concerning health which he receives, there is no cause for astonishment when he seeks a remedy from some prophet who promises to cure him. The physician knows that the body and its ills must not only be considered as a whole but must also be envisioned for complete understanding in relationship to its environment and heredity.

Education of the Public

Can you deny, then, the great need of education rather than legislation? What a splendid thing it would be if these philanthropists and economists who desire to raise health standards would join forces with the medical profession in the solving of these problems. What a debt humanity would owe them if they united with the medical profession instead of instituting untried, revolutionary methods of making it over!

Superstition, fear and ignorance would gradually disappear. The pernicious evil of self-treatment by specifically advertised cures would be lessened. The worthless and dishonest services of cults and quacks would be revealed and minimized. Realization would come of the relationship to health of social evils, habits, environment, and heredity. The medical profession does not have cures and apparatus to apply to the ills of the body which are dependent upon the ills of society.

In order to understand this agitation to make over the medical profession, we have only to take cognizance of the radical trends of thought throughout the entire world. Our own country has not escaped the influence of these currents of thought and we see increasing governmental interest in civil and industrial activities.

We heard little of socialized medicine until the depression devastated the business

and morale of our citizens. Now it would appear as though most of the ills of humanity could be laid at the door of the medical fraternity. There were no grounds for complaint until this economic confusion occurred. It is inevitable, in times of crisis and despair, for self-appointed evangels, imbued with a sudden burning and consuming humanitarian thirst to rise up and lead the discouraged, who with outstretched arms and eager faces follow with childlike trust only to find disillusionment and frustrated hopes.

Human nature has ever been thus. I challenge the statement that we need to change our institutions. Honesty, thrift, integrity, and sanity of outlook are still fundamental. Patronage and dependence are likely to undermine the character and breed laziness, insolence and revolution. Should we not hold steadfastly to those established institutions which have stood the test regardless of failing confidence and economic confusion? Should we not cling unwaveringly to individualism in medicine until the wheel turns again when sanity, work, and thrift will be fundamental?

Medicine an Art

Although the science of medicine was little, if at all, understood in early days, the art of the physician was in bringing sympathy, cheer, and restoration to health. Formerly the physician was the family counsellor in many problems aside from that of illness. No one, not even the spiritual adviser, knew the troubles that beset the family circle better than he. No one came closer to the inner life of the family. It was he who inspired that confidence and trust which stimulated the will to believe and to get well. It was he whose counsel was sought when trouble, trial, and tribulation laid their heavy hands upon the family life.

However, the practice of medicine is not the simple thing that it was in those days. There has been a tendency to regard specific diseases as separate entities, which has probably resulted in overspecialization. For complete understanding the entire organism must be considered as a personality. We, as a profession, are likely to fall into the same trap as those economists who would make medicine a businesslike science. Their theory is predicated upon the assumption that sickness and disease can be classified in the same manner as botanic specimens, and all that is necessary is to apply the cure. This is far from the truth. It is the personality, the ego, that is frequently out of adjustment with its environment. Stress and strain of economic existence and the pull of hereditary factors are at the bottom of many illnesses. Our profession has given too little thought to these ills with the result that psychologists and psychoanalysts have supplied the need of these suffering individuals. These personalities need sympathy and friendly counsel as does the parched field need the gentle rain. Let us give more thought and attention to the personality! Let there be a return to the family doctor and less specialization!

Those who talk so glibly of making over this profession of ours—this profession rich in traditions, this profession which has attained such noble worth, this profession actuated by kindness and sympathy, whose only passwords are mercy and pity—lose sight of the art of medicine. They would by a stroke of the pen destroy this almost divine principle; they would reduce to a formula all these human attributes of kindness, pity and mercy. They would put the matter on a business basis under the assumption that only scientific medicine need be applied to the sick in order to effect a cure. What an abysmal misunderstanding of the principles involved! What gross injustice and what cruel denial would result to many personalities! The art of medicine and its application must remain unchanged. Nothing must make unheard those words so often expressed by the sick, "Doctor, I'm so glad you have come." There is wrapped up in that one sentence the epitome of the medical art which has existed through the centuries. It is akin to the child who reaches out his hands to his mother and finds solace and understanding in her arms.

Altruism and Aims of Profession Unquestioned

Is it not our duty, by virtue of our training and knowledge of medical problems, to protect the public from the adoption of suddenly conceived, overnight schemes which

would result in the deterioration and prostitution of the medical art? Can our motives be impugned; can we justly be called selfish when we strive to maintain the finest quality of medical service in the world? Can we be reproached, can we be convicted of deceit when we oppose the control of medicine by politicians with all the inevitable and shameful patronage and waste in which such control elsewhere results?

We earnestly affirm our desire of instituting any changes made necessary in view of different economic conditions. However, we want those innovations to come gradually, to be built up solidly by trial and error. Science grows thus, an observation, a fact, finally a proof. So with us. Let changes follow the due course of events. Let there be no radical stampede resulting in disappointment, retrogression, and frustrated hopes. This is my answer to those of our profession who clamor and cry for a definite militant program of our own. It would take divine wisdom to foresee the future, but it requires only common sense to keep constantly before ourselves, before the public, and before our legislators the necessity of maintaining unsullied whatever is noble and worthy of the medical art. The only guide we have for the future is experience. Experience is largely the record of our mistakes. Lord Byron said, "The best prophet of the future is the past." There is ample evidence in events of the past of the deterioration of medicine under political influence. There has been no particular dissatisfaction of the public with the present type of medical service.

Vital Necessity of Interest and Leadership

I have considerable faith in the intelligence and motives of our legislators. I cannot believe that they, with a complete knowledge of such experience, would countenance any such system. Our duty is to be alert and to exercise constant vigilance and intelligent persuasion. There must be a revitalization, a sincere awakened interest on the part of county medical societies and especially of their committees so that the public and our legislators can be properly informed. The general lack of interest and enthusiasm excites my wonder and at times my shame. You leave this fight to your officers and to the faithful, and then many of you complain with bitterness of heart and spirit if the opposition wins. The greatest problem we have today with the medical profession is their indifference to the welfare of their own salvation. They do not take the necessary interest in the live problems which confront their own members. There is need for a desperate and definite effort to lead the public in the new fields of general practice.

As physicians, we have been mainly concerned with the bedside care of the sick. Now with the monumental, radical changes in the entire world today, we find ourselves untrained, uninterested, and unprepared to assume leadership and to influence constructive thought to direct these changing currents.

We are dedicated to the care of the sick and to the relief of suffering. We must assume the leadership and direction of all health matters. This is justly ours. We have been the protectors of body and mind down through the ages. This prerogative and duty should not be relinquished.

There is need for increased enthusiasm, alertness, and vigilance on the part of every county medical society in this state. No society is stronger than its individual members. These members should be joined so strongly that they function with unity of purpose and motive.

Over 2,500 members of this Society, with their culture and knowledge, represent an invincible force for good. How great this would be if they were filled with enthusiasm and imbued with the justness of their cause! Battles are won by those who are united in motive and purpose and fortified by an abiding faith that their cause is just.

All these things are practical. They are not ethereal or intangible. Your attention is called to the fact that organization, the molding of public opinion, resulting in the formation of laws, is the only method of those who oppose us. Are we to be so easily outdone by

those who so glibly describe our reorganization? Are we to relinquish leadership to those incapable of assuming it?

We have a duty to the public and to ourselves. A charge from those whose heritage we prize; those whose minds and hearts must have been akin to the Divine because of their noble motives and purposes; those who gave us the tradition of beneficent service to all who suffer. Their spirit is not dead! Their precept and principles, examples and teachings will live not only in the pages of history but in the hearts and minds of all those worthy to be called physicians.

The Treatment of Peritonitis and Ileus*

By GROVER C. PENBERTHY, M. D. and CLIFFORD D. BENSON, M. D.**
Detroit

PERITONITIS and ileus carry the highest mortality of any common conditions found in the abdominal cavity. The management of these conditions is important in the control of the excessively high mortality. Good surgery, which must embody strict asepsis, gentleness in manipulation, and careful hemostasis, has proved by experience to be the best form of prophylaxis against peritonitis following surgical procedures.

Several forms of prophylaxis against peritonitis have been suggested. It should be emphasized that regardless of how logical these measures might seem, there is nothing which can supplement good careful surgery. Recently there has been proposed the use of coli-bactragen[1] (Escherichia coli and gum tragacanth mixture) for the control of peritonitis, especially in colon surgery. It is not possible to evaluate how effective coli-bactragen has been in the prevention of peritonitis in these patients since careful controls are difficult. Peritonitis produced experimentally apparently has yielded to the use of this material, but in clinical studies the results have not been as striking as might have been anticipated.[2] Not only is this true of coli-bactragen but also for other materials introduced into the peritoneal cavity to prevent peritonitis. Basically it would seem that the policy of introducing extraneous material into the peritoneal cavity might cause a reaction with as much possibility of a deleterious effect as an advantageous one.

Roentgen therapy recently has been suggested for the prophylaxis,[3,4] and treatment[5] of peritonitis. At present the evaluation of this form of prophylaxis is difficult to interpret because of limited clinical experience. The results reported are encouraging and should serve as a stimulus for others to consider its application.

The factors predisposing to the development of peritonitis are partially under our control in operative patients, but less so in others classified as having primary peritonitis. The postoperative danger can be minimized by proper physical preparation of the patient, avoidance of operative trauma, and attention to the maintenance of adequate fluid and chemical balance, both preoperatively and postoperatively.[6]

Classification by the surgeon of the type and stage of peritonitis simplifies the mode of treatment. This can be done in the majority of instances by a careful history, physical examination, and laboratory studies. In infants and children, primary peritonitis must be considered in the differential diagnosis of acute disease of the abdomen. An abdominal paracentesis for bacteriologic study of the fluid is important, and if it is done properly and carefully, the danger is minimal. This diagnostic procedure has been used too infrequently as an aid in classifying the type of peritonitis; however, I will not discuss this group here but confine my remarks to peritonitis resulting from surgical procedures or inflammation in the abdominal viscera.

At the Children's Hospital, 15 patients have been classified as having had primary

* Presented at the Ninety-Ninth Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1940.

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peritonitis.[7] Table 1 illustrates the type of patients encountered and the mortality over a four-year period.

TABLE 1

PRIMARY PERITONITIS IN CHILDREN

Type	Patients	Lived	Mortality Rate Per Cent
Streptococcus haemolyticus	9	3	33⅓
Pneumococcus	6	2	33⅓

Recent advances in chemotherapy, namely, the use of sulfanilamide and the related compounds, are a valuable adjunct not only in controlling the bacteremia but also in helping minimize the incidence of complications. It will be noted from Table 1 that of the 9 patients suffering from primary hemolytic streptococcus peritonitis, the only ones who recovered were those treated with sulfanilamide. Of the 6 patients who had primary pneumococcus peritonitis, 2 lived. Both received type serum and sulfanilamide or a related compound. In this form of therapy it is desirous to maintain an adequate blood level of 6 to 8 mg., which is usually considered effective. In the study of a large series of patients with similar infections,[7] it was observed that the use of sulfathiazole will probably supplant sulfanilamide and sulfapyridine.

In a consideration of peritonitis it is important that the surgeon recognize the extent, the organ from which the infection is derived, and the nature of the affecting organism.[8] The most common source of infection is lesions of the gastro-intestinal tract, especially lesions of the appendix. Peritonitis resulting from perforating appendicitis may be classified as local or diffuse. Early surgical intervention is indicated for appendicitis complicated by a beginning peritonitis. When to operate, and when and how to drain, are important problems in peritonitis complicating acute appendicitis. The best guide on when to operate depends largely upon the surgeon's experience. John B. Deaver[9] frequently remarked that the surgeon's mind must be a veritable museum of experience to which he can refer when confronted with doubt. By correlating his collected exhibits in this museum he is, or should be, able to evaluate conditions in a given case.

There is no conservative treatment for appendicitis alone.[10] Appendectomy should always be done. However, in patients who have already developed peritonitis conservative treatment is of value, since operative trauma may produce a fatal result. Conservative or deferred treatment is more difficult than radical treatment and taxes the judgment of even the most experienced surgeon.

The generally accepted treatment of diffuse peritonitis is conservative, with a need for supportive treatment, the patient in a semi-Fowler's position or the head of the bed elevated on blocks, with sedatives as indicated. The intestinal tract should be placed at rest, and this is accomplished best by withholding fluid and food by mouth and early intubation, either duodenal or intestinal. Parental fluids should be given intravenously or subcutaneously. It is our practice to give 5 per cent glucose and saline the first twenty-four to thirty-six hours, the amount depending upon the size of the individual, the blood chemistry studies, and the urinary output. Subsequent to giving saline, 5 per cent glucose in water is given as indicated. Whole blood and plasma should be considered in the treatment. Heat to the abdomen by the use of the light cradle is preferable to stupes and other forms of moist heat. Oxygen therapy[11] is effective and restful to the distended patient. A rectal catheter often relieves the patient of an accumulation of gas in the lower large bowel.

If this form of therapy is practiced for five days, future treatment of the peritonitis will depend upon the reaction of the patient to the infection and the treatment. The use of enemas is condemned, as this treatment has little to offer except perhaps empty the lower portion of the colon, and many times the condition which one is trying to alleviate is made worse. In the event the process is a localized peritonitis, there may be clinical evidence of walling off, which usually appears within the first week. If it is of appendiceal origin, it may or may not require drainage. In children it has been ob-

served that many appendiceal abscesses go on to absorption under conservative treatment. In the event the abscess absorbs or is drained, the patient is advised to return within two months for appendectomy. Localized processes following streptococcus or pneumococcus peritonitis should be treated in very much the same manner,—by simple drainage where localization is apparent.

The patient suffering with peritonitis and ileus is the victim of two conditions, either one of which may cause death. In most instances in which both may be present, it is not possible to determine which is causing the major portion of the difficulty. Therefore, it is important to relieve these patients of distention to remove this lethal factor. Paralytic or adynamic ileus has long been a serious problem to every conscientious surgeon. That this complication is one which taxes the ingenuity and resources of even the most experienced surgeon is evidenced by the multiplicity of methods proposed for its relief.[12] In 1918, the mortality in three of the leading university clinics of this country was 66 per cent.[13]

The causes of ileus may be classified as follows:[12] (1) postoperative, presumably on the basis of trauma; (2) intraperitoneal inflammation,—peritonitis, abscess, etc.; (3) extraperitoneal inflammation, trauma, toxemia,—retroperitoneal, hematoma, fractures of the spine and pelvis, renal lesions, pneumonia, etc.

Experimental evidence indicates that adynamic ileus is produced by the agents named through a reflex inhibition of the normal intestinal motility.[14, 15, 16] A physiologic ileus follows laparotomy,[15, 17] and it is only when it fails to subside that it can properly be termed paralytic or adynamic.

Various forms of treatment have been proposed, and their very multiplicity is eloquent testimony to the fact that no one of them has proved uniformly satisfactory.

Once adynamic ileus has appeared we are faced with the need for some means of reducing the distention with a minimum of disturbance to the patient. Methods of treatment which have been proposed may be listed as follows:[18]

1. Enemas and local applications
2. Drugs
3. Oxygen therapy
4. Spinal anesthesia
5. Enterostomy
6. Suction drainage
   a. Gastric
   b. Duodenal
   c. Intestinal

In previous publications[12, 18] the futility of some of the various methods of therapy has been emphasized. The management of adynamic ileus is not a simple one. The abnormal distention from paralytic ileus, while exceedingly dangerous to the patient and troublesome to the surgeon, is frequently ignored in the hope that it will disappear. Often the first serious attempt to correct the difficulty is by enterostomy, and even this is not undertaken until the patient is exhausted from long continued distention. The following history[12] illustrates the somewhat complacent viewpoint held by many in the management of adynamic ileus:

Case Report

A 16-year-old girl underwent an appendectomy for perforated appendicitis. The abdomen was closed without drainage. The operation, which was done under spinal anesthesia, lasted for forty-five minutes.

Two days postoperatively some distention was noted and hot stupes to the abdomen were ordered. The following day an increase in distention was observed despite functioning gastric suction drainage for two days. On the fourth day the incision was opened, and a foul sanguinopurulent drainage was obtained. On the eighth day there was profuse drainage with a foul odor. No abdominal masses were felt, but the distention was such as to obscure any if present. Supportive measures were continued. On the ninth day the patient appeared better, her pulse was stronger, but the distention was unchanged.

Since there was some decrease in distention, the gastric tube was removed fifteen days postoperatively. Despite a roentgenogram on the sixteenth day revealing marked distention of both large and small intestines, gastric suction was not resumed until the seventeenth day. Distention was finally relieved by the nineteenth day, at which time the gastric tube was removed.

This patient was discharged as "improved" after thirty-five days in the hospital. Her stormy convalescence was undoubtedly influenced for the worse by the long period of distention.

This case history illustrates well the all too common viewpoint regarding distention,

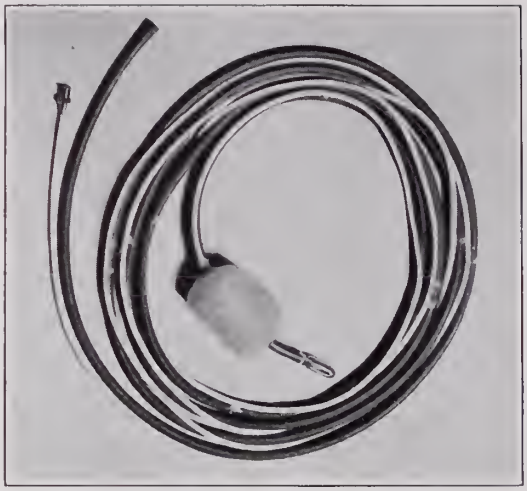

Fig. 1. Miller–Abbott tube.

even when long continued, as a situation more or less to be expected and tolerated in the hope of relief. Only when it is apparent that the situation is becoming dangerous to life is active treatment considered, and the most frequent procedure is enterostomy. Some of these patients recover and others die, despite enterostomy. Enterostomy, if used at all, should be performed before the contractile power of the intestine is lost completely. Its basis is the mechanical removal of the distending contents, and would seem a logical approach to the problem. However, it has the disadvantage of draining but one loop of intestine; this loop is usually drained unsatisfactorily and only for a short period of time.

Matas,[19] Ward,[20] Bassler[21] and others were early advocates of gastroduodenal drainage or lavage for relief of the harmful accumulations in the upper reaches of the intestinal tract. Wangensteen and Paine's[22] advocacy of continuous duodenal suction siphonage represents one of the epochal advances of the present generation. Based upon sound experimental work, use of suction drainage as postoperative prophylaxis results in avoidance of much of the distention previously encountered following operation. The work of Wangensteen[23] and of McIver[24] demonstrates that approximately 70 per cent of the gas in a distended intestinal tract results

Fig. 2. Gaseous distention apparent sixteen days postoperatively.

Fig. 3. Marked postoperative distention. Intestinal tube just past the ligament of Treitz.

from swallowed air. Wangensteen[22] has shown that in the treatment of distention, duodenal suction will evacuate much of the intestinal tract. Use of this principle has greatly simplified and improved the treatment of gaseous distention whether mechanical or reflex in origin. It is important to recognize that the Wangensteen principle implies not gastric, as understood by many, but duodenal suction; a tube in the second portion of the duodenum is much more effective in its relief of distention than one which does not go beyond the pylorus. Nevertheless, despite duodenal suction, many patients are still unrelieved.

Observing the success of this device in physiologic studies, it occurred to Johnston[25] that the Miller–Abbott tube might have an application in the treatment of intestinal obstruction. The method was tried with gratifying results. Subsequent reports[13, 26, 27] have confirmed the early success of the method.

Briefly this consists of use of a ten-foot tube known as the Miller–Abbott tube (fig. 1), near the distal end of which is attached a balloon with a means for inflation and deflation. Suction drainage is instituted when the tube tip enters the stomach, and when the distal end enters the duodenum, like any other suction tube the balloon is inflated. The peristaltic action now propels the balloon onward, dragging the tube after it. Continuous suction ahead of the balloon is essential, as obviously it cannot be acted upon by peristalsis until the intestinal wall contracts on its surface.

By means of this device the tube can be passed to the point of a mechanical obstruction, or throughout the small intestine in cases of adynamic ileus (fig. 2). The tip not infrequently has emerged from the anus. At first used only for organic obstruction, the balloon-tipped tube was tried in cases of adynamic ileus. There was some doubt of success because it was thought that the tube could not be propelled onward because of paresis of the intestine. However, the early cases indicated, and later work has confirmed the fact, that the paresis in these patients is only relative. Sufficient muscular power remains to propel the balloon onward (fig. 3) once the distention is relieved (fig. 4). In the study of 200 patients[28] (Table 2) with appendicitis at the Children's Hospital, 24 were classified as requiring decompression by gastro-intestinal intubation. Appendicitis is probably the most frequent cause of severe ileus in children. It is interesting to note the incidence of ileus (fig. 5).

Fig. 4. Decompression practically complete. Redistention of stomach necessitates additional gastric tube.

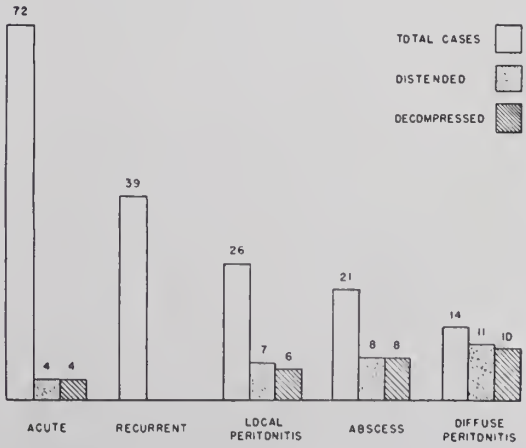

Fig. 5. Appendicitis and distention. (Surgery, Gynecology and Obstetrics, 71:212.)

TABLE 2*

ADYNAMIC ILEUS COMPLICATING APPENDICITIS IN CHILDREN

Type	Cases	Distention			Decompressed		Result	
		Mild	Moderate	Severe	Stomach or duodenum	Intestine	Lived	Died
Acute	96	1	2	0	3	0	96	0
Recurrent	45	0	0	0	0	0	45	0
Abscess	21	3	3	2	7	1	21	0
Local peritonitis (perforation)	25	4	1	1	5	0	25	0
General peritonitis (perforation)	13	0	6	4	6	2	12	1
Total	200	8	12	7	21	3	199	1

* Lahey Birthday Volume, 1940.

The selection of an incision which approaches the appendix from directly over the cecum has undoubtedly contributed to the low incidence of postoperative peritonitis and distention. In those cases in which ileus did occur, early use of the tube tended to reduce its severity and duration. It is likewise interesting to note the direct relationship between the severity of the disease and the incidence of ileus.

It is worthy of note that a balloon-tipped tube (Miller–Abbott) lying in either the stomach or duodenum will provide drainage from these areas equal in efficiency to the Levin or Wangensteen tube, with the added advantage that it can be passed further down the intestine when gastroduodenal drainage is inadequate. In this series (Table 3), gastric and/or duodenal suction was effective in 21 patients (87.5 per cent), while in 3 (12.5 per cent) relief was obtained only when the tube tip had been passed into or beyond the jejunum.

TABLE 3**

RELIEF OF DISTENTION IN CHILDREN

Cases decompressed	24
Suction from stomach or duodenum	21
Suction from intestine	3

** Lahey Birthday Volume, 1940.

Conclusions

1. Peritonitis and ileus carry the highest mortality of any common conditions found in the abdominal cavity.

2. Several forms of prophylaxis against peritonitis have been suggested, but there is nothing which can supplement good careful surgery.

3. Peritonitis and ileus can be minimized postoperatively by proper physical preparation of the patient, avoidance of operative trauma and attention to the maintenance of an adequate fluid and chemical balance.

4. The proper classification of the type and stage of the peritonitis simplifies the mode and effectiveness of the treatment.

5. Chemotherapy is a valuable adjunct not only in controlling bacteremia but also in helping minimize the incidence of complications.

6. Lesions of the appendix are the most common cause of peritonitis.

7. Physiologic rest of the gastro-intestinal tract in peritonitis and the associated ileus is important and can be accomplished best by withholding fluids by mouth and the use of gastro-intestinal intubation and suction.

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The Treatment of Puerperal Infection*

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IT GIVES me great pleasure to have the opportunity of speaking to this group of Wisconsin physicians, since I understand that over 99 per cent of Wisconsin babies are delivered by physicians. In other words, I am able to bring my message before the very group to which is entrusted the lives of Wisconsin mothers during childbirth. I wish to compliment you upon your most recent record of twenty-eight maternal deaths per 10,000 live births. More Wisconsin expectant mothers live through the childbearing period than do mothers in other countries and many other states. Your excellent record has been attained through the effort of the medical profession of Wisconsin and the educational efforts of your State Board of Health. May you continue to maintain your fine record and even improve upon it.

Perhaps I am presuming to speak to you on the question of maternal mortality when the record of my adopted state (Missouri) is not nearly as good as my native state (Wisconsin). However, I do feel justified by the records obtained at St. Louis City Hospital, No. 1, and St. Louis Maternity Hospital where my work has been carried out. These will be presented later.

Puerperal infection results when the female generative tract has a lowered resistance to the organisms which invade it during or following delivery or abortion; or

* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.
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when the virulence of the invading organism is unusually great. Of course, both conditions may be present in the same patient. Intrapartum infection is probably much more frequent than is generally believed and can only be prevented by early prophylaxis.

Contamination of the genital tract may be either (1) endogenous, due to organisms harbored by the vagina; or (2) exogenous, due to organisms introduced from without. Prevention of the first type of infection is possible if prophylaxis is started early enough in labor. The latter type of infection must be controlled by preventing the introduction of organisms from without by proper surgical technic: asepsis, antisepsis, proper masking and conservative obstetrical intervention.

A résumé of the findings which have been made since our study of puerperal infection was begun in July, 1924, may be helpful to those who encounter this disease with its various manifestations.

In the report of the Children's Bureau,[1] puerperal septicemia was given as "the most important cause of death connected with pregnancy and childbirth. It caused forty per cent of the 7,380 deaths included in the study." A later report for 1937 stated infection to be the cause of death in 35 per cent of the cases. Sepsis has maintained a relatively level curve from 1915 to 1937[2] as a factor in maternal mortality in the United States. Deaths assigned to this cause have ranged from twenty-four to eighteen per 10,000 live births during this period. Such reports make us realize the great importance of puerperal infection as a stumbling block in our attempts to lower the high maternal mortality rate of the United States as compared with certain foreign countries.

Another point brought out in the report is that infection, in the fatal cases, developed in the hospital is but 15 per cent. This seems to counteract the general impression that most cases of infection develop in hospitals, probably because of too great a tendency to interfere with the course of labor or abortion.

The observations of Schottmüller[3] led Drs. O. H. Schwarz and W. J. Dieckmann[4, 5] to investigate the bacteriology of the cases in our service and they soon confirmed his findings. The most important point was that a group of anaerobic streptococci which had been overlooked or considered only as nonpathogenic saprophytes was really accountable for a very large percentage of cases of puerperal infection.

In a series of 246 cases[6] of puerperal infection treated by the Obstetrical and Gynecological Service of Washington University, anaerobic organisms were isolated from the uterus in 84.1 per cent. The number of deaths was thirty-one and analysis of causes is shown in Table 1.

TABLE I

		Type (Colebrook)
Peritonitis	16	III
Septicemia	10	IV
Thrombophlebitis	4	II
Pelvic abscess (ruptured)	1	II
	31	

If these cases are classified on the clinicopathologic basis of Colebrook,[7] a very important point is emphasized; namely, that peritonitis is probably the most serious complication of all. Septicemia may respond to various types of therapy, but when a true peritonitis develops the prognosis is most guarded.

Schottmüller stressed the relationship between thrombophlebitis and the anaerobic streptococci. We observed the same findings in our series and lost 4 out of 15 of our patients over a period of five and one-half years. Since January, 1930, we have not had such a death. This is probably due to two main factors: (1) prophylaxis and (2) early active treatment of uterine infections. Of late we observe only an occasional mild case of thrombophlebetis.

As stated above, we have had thirty-one deaths due to puerperal infection. Upon further analysis it is brought to our attention that thirteen of these deaths occurred among patients delivered by our service, eight of whom were delivered by cesarean section.

TABLE II

TYPES OF ORGANISMS IN THIRTY-ONE FATAL CASES

Anaerobic streptococcus	15	(4)
Hemolytic streptococcus	7	(2)
Staphylococcus albus	7	(6)
Streptococcus viridans	1	(0)
Nonhemolytic streptococcus	1	(1)
	31	13

The incidence of infections due to *Staphylococcus albus* was found to be due to faulty technic in the sterilization of gloves and was soon corrected. Note the important role played by the anaerobic streptococcus in these fatal cases whether delivered in the hospital or outside.

Upon noticing the importance of infection as the cause of mortality following cesarean section, we undertook the study of the bacteriology of the uterus at the time of operation and correlated the findings with the use of antiseptic vaginal instillations. The antiseptic used was 1 per cent neutral acriflavine in glycerin, as described in a recent article.[8] The instillation is best given with an asepto syringe No. 2042. This syringe holds 8 cc. (average dose) and is rubber tipped so that it can do no serious damage. An instillation is given upon admission and repeated every four hours if the patient is in active labor. In waiting cases at or near term and cases which may be delivered by section, instillations are ordered given once daily unless the membranes have been ruptured when instillations are given twice daily.

As a control group for this study we refer to the report of Harris and Brown[9] in which cultures were obtained in the same way, but no instillations were used. The contrast is very marked. In their study of 50 patients, uterine culture was positive in 44 per cent. They noted the predominance of anaerobic streptococci. Anaerobic growth was obtained in 45 per cent of the positive cultures. "No sterile cultures were obtained from patients in whom active labor had lasted for six hours or more and only one positive culture was obtained where labor had progressed less than six hours . . . when cesarean section is definitely indicated the ideal time for its performance is at an appointed time at the end of pregnancy or at the very beginning of labor. . ." Later in labor they suggest employment of the low cervical section or the radical procedure (supravaginal hysterectomy).

In a series of 144 cases studied at the St. Louis Maternity Hospital, the incidence of positive uterine culture was 4.1 per cent when vaginal instillations of acriflavine were employed. Anaerobic growth was present in 83 per cent of the positive cultures. Intrapartum infection accounted for 50 per cent of the positive cultures. A negative uterine culture was obtained as late in labor as 107½ hours with the use of instillations. In two cases forceps delivery was attempted before section was performed and the uterine cultures were negative. Since 1931, puerperal infection as the cause of mortality associated with cesarean section has been eliminated, apparently due to the use of antiseptic vaginal instillations. The indication for the radical procedure of supravaginal hysteroctomy because of infection has been avoided. This technic makes it relatively safe to postpone section until a much later hour in the labor than has been recommended by other reports.

In the report on maternal deaths,[1] abortion was reported in 45 per cent of the deaths due to septicemia. The report for 1937[10] mentioned this proportion as 40 per cent. In the study of uterine cultures in 2,000 abortion cases at St. Louis City Hospital, 60 per cent were found to be positive. Anaerobic growth was obtained in 94.3 per cent of the positive cultures. This again emphasizes the importance of this group of organisms in puerperal infection. Contrast this with the lower incidence of the hemolytic streptococcus, which was found in 6.8 per cent of a series of 1,776 uterine cultures.

The importance of the hemolytic streptococcus is not to be belittled for a moment when it is present and causing the disease. In the twenty-two deaths which occurred in the series of 2,000 abortions between 1931 and 1939, 35 per cent showed hemolytic streptococcus present in the uterine cultures and 25 per cent in the blood cultures (mortality 1 per cent).

In view of our results,[11] it seems advisable to continue the active gentle treatment of the uterine cavity, as early as possible in cases of suspected uterine contamination: (1) to obtain the diagnosis; (2) to determine the type of organism present; (3) to arrest blood loss; (4) to shorten convalescence; and (5) to avoid complications. Do not use a sharp curete in the treatment of such cases.

Posterior colpotomy is of great value in the treatment of patients who develop pelvic infections that finally point in the cul-de-sac. A word of caution should be given in regard to the handling of such cases: wait until the process is well localized. If possible, avoid the use of general anesthesia during the procedure for fear too much force may be used and result in the rupture of such an abscess into the peritoneal cavity as has occurred in a few instances. Insert a good sized '*T*' tube and allow it to remain in place long enough (usually six weeks). Such a tube should be cut spirally in order to avoid too much pressure against the vaginal wall with resultant erosion and possible perforation of the rectum.

The death rate from puerperal infection has been increased five times by operative delivery as compared with spontaneous delivery.

I should like to condemn the too frequent use of rectal examinations, especially if vaginal antisepsis has not been used. By such examinations the organisms of the vaginal flora are carried up into the cervical canal where they are ordinarily absent and endogenous infection may result. I saw a typical case of this type in the last week. Eleven rectal examinations had been made during the course of an average labor, but no vaginal examination, and all without benefit of antiseptic instillations. The patient developed a typical anaerobic infection with pelvic thrombophlebitis.

A vaginal examination properly done is much less dangerous to the patient and reveals so much more to the operator. Therefore, examinations will be less frequently necessary. When a vaginal examination is done avoid the common error of allowing the fingers outside the vagina to contact the anus or hemorrhoids which is another source of anaerobic contamination.

Vaginal instillations should be given before any vaginal or rectal examination is done and every four hours during labor.

Prevention of maternal mortality from infection will result from: (1) thorough surgical preparation of patient; (2) excellent aseptic technic; (3) proper use of masks; (4) antiseptic vaginal instillations; (5) prompt isolation of infected patients; (6) early gentle evacuation of uterine debris and establishment of adequate drainage; (7) transfusions as indicated; (8) chemotherapy when indicated.

Without the assistance of chemotherapy the maternal mortality from puerperal infection in obstetric cases at Washington University has been:

	Deliveries	Deaths
July, 1924–Jan. 1932	9,529	13
Jan. 1932–Jan. 1941*	14,789	0

* Vaginal instillations used during this period.

These results coincide with the statement of Schottmüller: "Heute muss es also heisen: Die Gefahr kommt weniger von Aussen als von Innen.[12]"

Treatment

Transfusion is probably the best therapeutic agent we have available. One should be guided by the hemoglobin level and try to maintain it between 90 and 100 per cent. The anaerobic streptococcus causes marked anemia due to its proteolytic action on red cells, and frequent transfusions of from 500 to 750 cc. seem to give best results. Immunotransfusion is of value if proper donors are available. In 1,276 consecutive abortions transfusions were given in 177.

Chemotherapy with drugs of the sulfanilamide group should not be used indiscriminately because of the possible by-effects which make the patient feel miserable and may inhibit her recovery. They also frequently mislead the physician into the belief that the patient is much worse off than she really is. When the bacteriologic findings in a given case indicate that this group of drugs might be of value, one may proceed

cautiously with close observation, using the least toxic preparation available and giving moderate doses over as short a period as possible. The results of such therapy are not 100 per cent good even in patients infected with the hemolytic streptococcus. It is necessary to follow closely the effect on the red blood cells, white blood cells and hemoglobin, and to check the level of the drug in the blood stream from time to time. There is no evidence of the value of this group of drugs in patients infected with anaerobic streptococci, and since these organisms most frequently are the offenders in puerperal infection, it is wise to omit sulfanilamide medication until the hemolytic streptococcus is proved to be present. It seldom is present when the obstetric care of patients is what it should be. Perhaps later we may have some related drug which will be of more general value.

The reports of Colebrook and Purdie,[13] Morris,[14] Chandler and Janeway,[15] and Waters,[16] suggest the value of sulfanilamide and allied drugs in the treatment of puerperal infection, but their results are not very convincing since similar results are obtained without such drugs. In 1,276 consecutive abortions, 30 patients received sulfanilamide, and 8 of this number died.

When a patient in the puerperal state develops signs of infection, which cannot be accounted for after the usual diagnostic methods have ruled out all other possible infections, it seems justifiable to investigate the uterine cavity. The surgical principles involved in our treatment of such cases are: (1) drainage of an infected wound site, and (2) débridement of a potentially infected cavity. This is done with a minimal amount of manipulation in order that further trauma may be avoided. We have demonstrated that this procedure can be safely performed by a junior interne under proper supervision. A general anesthetic is not used, because this would remove the inhibiting influence of the patient's response to pain which is usually indicative of too active manipulation. The patient should be under the influence of some sedative so that she is not too apprehensive. Morphia (.01 Gm.) with hyoscine hydrobromide (0.0005 Gm.) followed by hyoscine (0.0005 Gm.) in forty-five minutes is given, the second dose administered at least thirty minutes before the patient is prepared for examination.

The perineum is prepared with tincture of mercresin. The bladder is *not* catheterized because of the danger of contamination which may frequently superimpose a urinary infection. Drapes are placed. A Graves' vaginal speculum is used to obtain exposure of the cervix. If this is not satisfactory, several vaginal retractors will be necessary. The vagina and cervix are then prepared with the above solution. The cervical canal is treated with the solution and dried carefully with sterile gauze. A culture is obtained from the uterine cavity with a modified Little tube. If it is not possible to have careful bacteriologic investigation of the material obtained, several smears can be made and stained by the Gram method. This has been done routinely and found to check very well with the bacteriologic findings. Both aerobic and anaerobic blood agar slants should be made. The Wright anaerobic technic is used in the search for anaerobic organisms.

After the culture has been obtained, a gentle bimanual examination is done to determine evidence of any spread of the uterine infection, pelvic abscess or thrombophlebitis. This is also done without an anesthetic in order that the patient's reaction to pain may limit the extent of the examination. Too much pressure might cause rupture of an abscess internally. The uterine cavity is very carefully investigated with a Foerster's sponge-holding forceps, plain jaw. Dilatation of the cervix is usually sufficient to permit this. The closed sponge forceps is inserted to the depth desired, opened, closed and removed to see if any tissue has fallen within the jaws. The forceps should not be advanced with the jaws open, because of the danger of grasping the uterine muscle. The uterine wall is next explored very systematically and with great gentleness by means of a "uterine wiper" (formerly called a vaginal depressor) much as a windshield wiper covers the glass of a windshield, without

marring the surface. (No curettage is done.)

The uterus is usually found to be relaxed in such cases. After mechanical removal of any retained debris, the patient is given an intra-uterine douche, using a Bozeman's extra large intra-uterine douche nozzle. This instrument permits the free exit of the solution from the uterine cavity without positive pressure being established. Two liters of a 1:1,000 solution of potassium permanganate in sterile water at 105 to 110 F. are used. This solution is usually acidulated with 50 cc. N/1 sulfuric acid. The bottom of the douche can is held at the level of the symphysis so that the water pressure of the solution as it enters the douche nozzle is 15 cm. or less. Such a douche results in: (1) removal of small bits of tissue remaining after mechanical emptying of the cavity; (2) firm contraction of the uterus, including the cervix, so that bleeding is controlled and the sinuses are closed; (3) elimination of the putrid discharge which is characteristic of anaerobic infections. It is seldom necessary to repeat the procedure.

Administer ergometrine (0.2 mgm.) intramuscularly, stat, and order ergometrine (0.2 mgm.) by mouth twice daily for eight doses.

Follow-up treatment:

- Semi-Fowler position;
- Icebag to lower abdomen;
- Ergot preparations;
- Rapidly increasing diet (if no peritonitis);
- Low pressure vaginal douches, lactic acid (1:2,000) beginning the third day, in cases of abortion or seven to ten days postpartum;
- Abortion cases start getting up on fourth or fifth day; postpartum patients are usually allowed up on the tenth day or after one week of normal temperature.
- Transfuse for anemia.

In cases with signs of peritoneal irritation:

- Nothing by mouth;
- Intravenous glucose;
- Subcutaneous saline;
- Transfusions, large and frequent;
- Wangensteen apparatus;
- No laxatives;
- Daily tap water enema.

If temperature remains elevated re-examine every second or third day to determine presence of pelvic thrombophlebitis or beginning pelvic abscess formation.

Discharge patient at end of one week after abortion or two weeks postpartum under conservative instructions.

Re-examine in two to three weeks.

Results

In the case of a patient treated early in our series, treatment was delayed for eight days, five transfusions were given, blood culture was positive, and the patient was hospitalized for fifty-two days. Of late, patients are treated actively much earlier, irrespective of the type of infection and rarely remain in the hospital longer than four days in abortion cases or two weeks after delivery. In 1,776 abortions, the period of hospitalization after treatment averaged five and nine-tenths days. Think of the economic saving!

Sterility does not uniformly follow abortion since in 1,276 consecutive abortions, 344 patients had had from one to three abortions; forty-five patients had had more than three. The largest number of abortions in one case was seven. Many other patients in this series have since returned to be delivered at full term.

Approximately 25 per cent of the abortion patients had a temperature of 101 F. upon admission.

Maternal mortality for the period from 1915 to 1937, as reported by the Children's Bureau (Chart 7880), shows no great improvement, so it behooves us all to increase our efforts in this direction.

During the five year period from July, 1934, to July, 1939, the routine care of patients at St. Louis Maternity Hospital was applied as nearly as possible at St. Louis City Hospital, No. 1.

MATERNAL DEATHS PER 10,000 LIVE BIRTHS
July, 1934 to July, 1939

State of Missouri	48.8
City of St. Louis	38.9
St. Louis City Hospital, No. I	27.7
St. Louis Maternity Hospital	14.9

I have been very much gratified by the record obtained at St. Louis City Hospital, No. 1. Although this is a hospital for the free care of white patients, many of them have had little or no prenatal care, especially those with complications. In spite of this handicap the results are excellent due to conscientious efforts of the house staff and the visiting staff.

Conclusions

Puerperal infection in the early stage is primarily a surgical disease, an infection of a wounded area (placental site), and should be treated accordingly. Drainage should be established early and maintained if necessary. All debris should be evacuated as gently as possible. Avenues for spread of infection should be closed by keeping the uterus well contracted. Complications are avoided by early treatment. Prophylaxis is accomplished by the early, consistent use of antiseptic vaginal instillations. These are of value in avoiding both endogenous and exogenous infection. Excellent aseptic technic with a minimum of interference by attendants will largely eliminate exogenous infection. Transfusion is of great value. Chemotherapy should be used when there is indication.

Roland S. Cron, M. D., Milwaukee: This discussion is based on a review of recent studies made at the Milwaukee County Hospital by Drs. A. C. Mietus, R. M. Mitchell, and Myron Schuster. A study made by Dr. A. H. Lahmann and the discussant in 1934 will be compared with a more recent one made by two of the above mentioned authors.

During the years 1931 to 1941, 14,479 women were delivered at the Milwaukee County Hospital. Sixty, or 4.1 per 1,000 of these women, died upon admission or subsequent to their entrance into that institution. Sixteen, or about one fourth of them, died from puerperal sepsis. Nine, or more than one half of these mothers, were delivered by classical cesarean section. More than one fourth of all of the mothers who died experienced some type of cesarean operation. On the basis of these statistics, it is quite apparent that the operation was performed many times when some other method of delivery should have been utilized. Suffice it to say that the operation was performed for the birth of a hydrocephalic child, in the absence of fetal heart sounds, after prolonged and exhausting labor, packing of the vagina, repeated vaginal examinations, ruptured membranes and without antiseptic preparation of the birth canal.

A study of this sort is an excellent thing for all concerned. It brings one face to face with certain facts and makes it imperative to correct errors that have crept into the practice of medicine and surgery. I am certain that the incidence of puerperal sepsis can and will be reduced at least 50 per cent by the observation of certain principles and practices that have been laid down by the essayist. Acts of the physician based on errors in judgment and technic are responsible in large measure for our high mortality rate.

Cesarean section should be used less often. The classical, or high incision, should never be performed. The low cervical operation is much safer. The contra-indications for the operation, such as prolonged labor, ruptured membranes, vaginal examinations, previous instrumentation, dead baby, anemia and fever should be observed. The practice of performing cesarean section in order to resect the Fallopian tubes or remove ovarian or uterine tumors or an appendix should never be condoned. Frequent instillations of some vaginal antiseptic during labor and the introduction of 5 to 10 Gms. of sulfanilamide into the potentially infected uterine cavity are advocated.

Postabortal sepsis has also been studied. In 1934 there were eighteen, or 3.3 per cent, deaths in the last 594 patients admitted to the County Hospital. Twelve, or two-thirds of them, occurred in patients who admitted either criminal or self-induction. Contrast this with the last 557 patients admitted, not one of whom has been a fatality. This illustrates the amazing improvement obtained in the care of the postabortal patient. It does not mean that there have been no deaths from abortions during the last four years since four fatalities occurred in the last 800 consecutive abortions. However, the reduction from over 3 per cent to .5 per cent is an appreciable one.

The solution of the abortion problem is one of prevention and cure. Criminal and self-induced abortions will probably be with us as long as social and economic conditions remain as they are. Education of the public as to the seriousness of the procedure may help. The active prosecution of those practicing criminal abortions, such as we are experiencing locally, assists in removing from the community some of the worst offenders. The restoration of more idealism in the married and unmarried women and the desire for larger families will also assist in solving this problem.

The amazing reduction in the mortality rate of the last few years has been accomplished by practicing a conservative technic in the care of all abor-

tions, as well as the very active treatment of the infected case. Trauma, as accomplished by digital examination, curettage or packing, is avoided whenever possible. Curettage is postponed until the patient is afebrile unless there is active and uncontrollable bleeding. Packing with 5 per cent mercurochrome gauze, when used, is removed in six hours and never left in position longer than twelve.

The judicious use of the sulfanilamide and sulfonamide-like drugs has been partly responsible for the marked reduction in our morbidity and mortality. The crux in the use of these drugs rests upon the administration of sufficiently high dosage over a sufficiently long period of time. This is attained by the determination of the sulfonamide blood level, the patient's blood picture and temperature, as well as the general condition of the patient.

Convalescent serum has been used, but we do not care to recommend its use due to its questionable efficacy and great expense.

Without a doubt, the greatest share of credit belongs to the most efficacious therapeutic agent we have at our disposal, namely, transfusions of whole blood. Let me quote from Mietus and Mitchell's study: "Infections attributable to the anaerobic streptococcus are characterized by an anemia due in large part to the proteolytic action of the organism on erythrocytes, and certain strains of this organism are notoriously resistant to chemotherapy. Whole blood, then, not only compensates for the blood loss due to the external hemorrhage which characterizes neglected abortions, but also combats the anemia due to the bacterial hemolysis. Its polyvalent effect goes further, for not only is it beneficial as a supportive measure—as physiological nourishment and to counteract dehydration—but its bactericidal effect is reflected by an immediate elevation of the phagocytic titer of the patient's blood. For the anemic, infected post-abortal patient, the administration of repeated small transfusions—250 to 500 cc. whole blood daily or on alternate days—is strenuously advocated."

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The Prevention of Rheumatic Heart Disease

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THERE are probably 24,000 persons in the State of Wisconsin who have rheumatic heart disease. This challenge is all the more commanding in wartime because young people, who are in the prime of life or who have not yet entered their period of economic production, are the most frequently affected. More than two thirds of the cardiac disease that occurs before the age of forty is on a rheumatic basis. In 1939 rheumatic fever and rheumatic heart disease killed five times as many Wisconsin persons as poliomyelitis, epidemic meningitis, scarlet fever, whooping cough, diphtheria and measles *combined.*[1] In this state acute rheumatism, alone, accounts for three times as many deaths as acute anterior poliomyelitis. The general public is keenly aware of the infantile paral-

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ysis problem because of the visible crippling effects, but the crippling that results from rheumatic fever is far more deadly.

The actual cause of rheumatic fever and chorea is not known and therefore prevention in the general population is difficult. We hear less of the ill fed, ill housed and ill clothed one third of our population now, but many of them are still with us. It is these poor people who suffer most from inflammatory rheumatism, and improvement in their general hygiene will be of prophylactic value. In view of the probable relationship between rheumatic fever and hemolytic streptococcic infections, we should cultivate a healthy respect for colds and sore throats. In one large group of patients, 58 per cent of first attacks were preceded by a cold or sore throat.[2] Children of "rheumatic families" who develop respiratory infections should be treated with extreme caution because of the familial nature of the disease.

Prevention of Recurrent Rheumatic Fever

Rheumatic fever is a chronic, recurring disease and the degree of heart damage usually increases with each exacerbation. About 30 per cent of children escape cardiac damage in the first attack, and a great many others have only slight valvular involvement. If relapses could be prevented, these children might lead a normal, active life. Too much care cannot be given to the rheumatic child in the first few years after the initial attack when recurrence is the rule.

General measures.—What can be done to prevent repeated attacks of rheumatic fever and chorea? Hopeful results of specific prophylactic methods have been reported, but general measures are still the most universally applicable. Poor housing and dampness predispose to recurrences, and if these young patients can be placed in a better physical environment, even to the use of a foster home, their chances of avoiding a relapse are better. Needless to say, the maintenance of adequate nutrition and the assurance of proper rest are essential. The disease is seasonal with the highest incidence of relapses in late winter and spring. Although it is impractical to transport large groups of patients, there is less likelihood of repeated attacks in a tropical or subtropical climate, and it has been found distinctly beneficial for rheumatic children to spend the winter and spring months in southern Florida.

Hemolytic streptococcic infections are so closely associated with recrudescences that a causal relationship is suggested. Jones and Mote[2] found that one half of the symptomatic sore throats experienced by patients with inactive rheumatic fever were followed by recurrences. Therefore, these patients should be put to bed when a cold or sore throat develops, and they should be observed for signs of reactivation after their recovery. Students of the subject are about equally divided on the value of tonsillectomy. In the Cardiac Clinic of the Milwaukee Children's Hospital we prefer to have a tonsillectomy performed when there is a history of rheumatic fever or chorea. Although removal of the tonsils may have no specific effect, we believe it is of value if it helps to prevent respiratory infections.

Education of the parents and the patient is essential, and they must be taught that recurrences are often insidious in onset. Malaise, fatigue, joint aches, low grade fever, epistaxis, anemia and failure to gain weight may be evidence of a subclinical relapse, and treatment with bed rest is indicated until it can be proved that the symptoms are not evidence of reactivation. The parents should be told that psychic and physical trauma, even dental extractions, may precipitate a bout of rheumatic fever. Members of the patient's family and his friends should understand the importance of protecting him from respiratory infections. What is only a cold in the head to his brother may become an attack of carditis to a rheumatic child.

Specific therapy.—The most promising results have been achieved with vaccines and sulfanilamide. Although Wilson[3] believed in 1940 that the value of vaccine prophylaxis had not been demonstrated, it is difficult to discount the work of Wasson and Brown.[4] Based on the assumption that a hemolytic streptococcic infection is the causative factor, they have attempted to immunize patients with rheumatic heart disease by the periodic injection of a filtrate of the or-

ganism. Their carefully controlled studies have now extended over a period of eight years, and they are convinced that the treated patients have been in better general health and have had a "striking reduction" in the number of recurrences.

The use of sulfanilamide and related drugs in streptococcic infections has led to their application in the treatment and prevention of rheumatic fever and chorea. It is now fairly well established that sulfanilamide is of no value in treatment of the acute phase of the disease; in fact, its use at this time may increase the activity of the infection. Coburn and Moore,[5] as well as Thomas, France and Reichsman,[6] have reported excellent results in the use of sulfanilamide prophylactically. Both groups found that small daily doses of the drug used during the winter and spring months decreased the incidence of recurrences. This form of therapy must be carefully controlled with regard to the blood sulfanilamide level and evidences of toxicity. In October, 1941, such a program of treatment was begun in the Cardiac Clinic of the Milwaukee Children's Hospital, but it is too soon to draw conclusions. It should be emphasized that the prophylactic use of sulfanilamide is still in the experimental stage, although published reports offer real encouragement.

Prevention of Heart Disease During the Attack

Even after rheumatic fever or chorea appears, proper management will prevent or minimize cardiac damage. The key phrase in treatment is "prolonged rest in bed." Swift[7] has cited experimental evidence that a reduction in the work of the heart reduces the amount of heart damage. When there is fever, the value of salicylate therapy is partially based on the same principle. A lowering of the temperature reduces the rate of the heart, thus decreasing the strain on that organ. During the acute attack when the patient is prostrated by the fever, swollen joints or the severe forms of chorea, both his family and he appreciate the need for bed rest. It is when the convalescence begins that the physician needs all his powers of persuasion. The patient must be taught that rheumatic fever is a chronic, smouldering disease which may flare up at any time, resulting in severe cardiac crippling or even death. He must not compare his rate of recovery with that of his friend who got over pneumonia or chickenpox so quickly. The rest in bed should continue as long as evidence of active infection is present.

Signs of rheumatic infection.—How can we be sure that the process is inactive? Physical signs of great value are the pulse, temperature and weight. A persistently rapid pulse (over 100) may be the only evidence of activity. Children who are required to spend weeks and months in bed are inclined to be introspective and, often, their pulse quickens on the approach of the doctor or nurse. If it is suspected that the tachycardia is on a neurogenic basis, the pulse should be counted while the patient is sleeping. In general the temperature is a reliable index of the presence or absence of active disease. During the convalescent period it is not uncommon to observe a daily rise in temperature to 99.5 F., or even higher. Any temperature above 99 F. is presumptive evidence of active rheumatism. Weight gain is a valuable guide and if a convalescent patient does not gain weight, while in bed, it is likely that he has not yet overcome his infection. Other signs of activity include subcutaneous nodules, the various erythemas, choreiform movements and evidence of progressive heart involvement. Highly suggestive subjective signs are joint aches, precordial or abdominal pain and epistaxis.

Even though it is nonspecific, the erythrocytic sedimentation rate is the most sensitive laboratory test for evidence of rheumatic infection. A rapid sedimentation rate is usually the last sign of activity to disappear. The technic of the test is simple, and it can readily be done in any office. The white blood cell count is not as sensitive a test as the sedimentation rate, but it may be useful in following the progress of the disease, and a count above 9,000 should be looked upon with suspicion. Anemia is a common finding in subacute rheumatic fever.

The electrocardiograph is helpful, but it is not essential in studying the progress of convalescence. A lengthening of the PR interval indicating delayed auriculoventricular

conduction is presumptive evidence of active carditis. Other electrocardiographic findings of more or less value include auricular fibrillation, premature contractions and elevation of the ST segment or inversion of the T wave found in pericarditis.

Resumption of physical activity.—When the rheumatic infection is quiescent, physical activity may begin. The pulse and temperature, without salicylate therapy, should have been normal for at least two weeks; the sedimentation rate or white blood cell count should be normal; other signs of activity should be absent. At the Convalescent Home of the Milwaukee Children's Hospital the patient passes through ten steps in his return to normal life. At first he is only allowed to feed himself; next he is permitted to sit up in bed for five or ten minutes; later he is allowed to be up in a chair for lengthening periods. He passes through seven more stages including short and then longer walks, until he reaches "full cardiac activity." Even in this last phase his exercise is still greatly restricted by rest periods before and after meals and an early retiring hour. If at any time during this slow progression there is evidence of rheumatic infection, such as tachycardia, fever or a rapid sedimentation rate, the patient's exercise is again restricted until it becomes clear that the disease is quiescent. During the first year after recovery, physical activity should be limited. Later, exercise within the limit of tolerance is allowed. If it is at all possible, a sojourn in a warmer climate should be considered in the late stages of recovery.

Convalescent home care.—The prolonged care required can best be given in a convalescent home, whether the patient's family is indigent or self-supporting. The effect of an improper home environment is eliminated, and the child is protected from indiscriminate exposure to acute infections. As members of a group, all of whom suffer from the same disease, these youngsters learn to be patient with their progress. Strict regulation of exercise, occupational therapy and school classes are advantages found only in an institution of this sort. During the long period of observation there is an excellent opportunity for the education of the patient and his family regarding the problems of the rheumatic state.

The average stay at the Milwaukee Children's Hospital Convalescent Home is nine months, and when this period is added to the month usually spent in the hospital while the disease is acute, the tediousness of home care for rheumatic fever and chorea can be appreciated. Unfortunately, the majority of patients have to be carried through their illness and recovery period in their own homes. When this is necessary, the child should be given the warmest, brightest room in the house where he is isolated from visitors and other members of the family. The same prolonged regime of convalescence must be observed.

Summary

Rheumatic fever is a chronic, recurring disease with danger of increased heart damage in each attack. It is responsible for a great deal of cardiac morbidity and mortality in Wisconsin. Prevention of relapses centers around general measures of good hygiene and avoidance of respiratory infections. Vaccine and sulfanilamide prophylaxis have shown encouraging results. Once rheumatic fever or chorea has appeared, prolonged rest in bed offers the best hope of preventing or minimizing cardiac crippling.

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The Treatment of Rheumatoid Arthritis With Gold Salts

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CHRONIC rheumatoid arthritis is a common disease and causes an appalling amount of morbidity and disability. Despite an enormous amount of investigation, we remain quite ignorant of many fundamental facts. Though this disease is considered generally to be of streptococcic origin, the evidence presented is far from conclusive and, even if accepted, fails to explain the peculiar type of tissue reaction seen in the connective tissues throughout the body. A few facts seem to be quite clearly established in relation to this disease and may be summarized as follows:

1. It is to be regarded as a constitutional disease, rather than a joint disease alone, and in many of its manifestations resembles a chronic infectious process such as tuberculosis. Chief among the manifestations of the constitutional nature of the disease are fever, loss of weight, fatigue, malaise, anorexia, leukocytosis and increased sedimentation rate.
2. Destruction of the joints is brought about by proliferation of the connective tissue of the synovial membrane and subchondral plate. The joint cartilage is choked in a web of fibrous tissue, which destroys the blood supply to the cartilage and eventually leads to its destruction. Since cartilage has no power of regeneration, this means permanent and irreversible destruction of the involved joint.
3. The disease is much more common in the younger age groups with its onset usually under forty, and is four times more frequent in women. The latter fact may be explained partially by the increased drain on the woman's vitality during the child-bearing period and particularly by the consequences of prolonged and difficult labor. In the present series three of the women accurately dated the onset of the disease to a difficult labor.
4. The disease tends to be progressive. Unless the process of fibrous tissue proliferation and pannus formation can be arrested, eventual joint destruction and permanent crippling will result.
5. The disease has a peculiar tendency to involve the proximal interphalangeal joints, giving rise to the spindle-shaped swelling of the fingers, a condition frequently, but by no means invariably, present.
6. The disease is marked by periods of exacerbation and periods of remission, such as are also seen in chronic nephritis and chronic tuberculosis.

We have to deal, then, with a chronic disease of unknown though probably infectious origin, and whose natural tendency is toward slow progression and ultimate crippling. In such a situation, treatment is necessarily empiric. So-called specific treatment, directed towards either immunizing or desensitizing patients to streptococci, has not been widely accepted, and today those[1] who were at first most enthusiastic about removal of focal infection are preaching great conservatism in regard to the use of surgery in this group of patients.

As in other chronic diseases many specifics have been widely heralded, at their introduction, but few have stood the test of time or of critical evaluation with suitable controls. Apparently, good results are frequently attributed to the treatment used, when actually they result from a spontaneous remission. Indeed it is probable that, regardless of the drugs used, any series of patients with rheumatoid arthritis, given an adequate diet and vitamin intake, sufficient rest, suitable physiotherapy, and enough aspirin to give relief of pain, would show from 60 to 70 per cent good results. It is for this reason

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that investigators have reported equally good results using such widely varied forms of treatment as sulfur, various vaccines, colonic irrigations, high dosage vitamin D, ertron, oxo-ate B, and bee venom.

The intravenous or intramuscular use of gold salts in the treatment of rheumatoid arthritis is largely on an empiric basis. It was first introduced in France by Forestier in 1929. He thought gold salts might be of value in the treatment of this form of arthritis, because they had previously been found to benefit certain cases of tuberculosis, a disease which in many ways resembles rheumatoid arthritis. Their mode of action in the body is not known, though it is known that gold, as all other heavy metals, is ingested by the phagocytic cells of the reticulo-endothelial system, not only of the blood, liver, spleen, and bone marrow, but also in the more or less fixed cells of this system found throughout connective tissues. Therefore, gold is found in the cells of the joint tissues, where its presence apparently has the effect of inhibiting and arresting the proliferative process.

It has been shown that gold is deposited in larger amounts in the tissues of inflamed joints than in those which are normal. Many of its toxic effects are related to its affinity for the reticulo-endothelial system, particularly in the liver and bone marrow. Another mode of action of gold is suggested by its known inhibitive effect on bacterial growth. Recently Hartung[2] has demonstrated that the serum of patients treated with gold is bacteriostatic for streptococci, organisms which many believe are etiologically related to the disease.

Whatever may be the true explanation of the mode of action of gold salts, a growing appreciation of their therapeutic effectiveness is manifested by increasingly favorable reports in medical literature.

In the five years from 1935 to 1939 seven major reports appeared dealing with a large series of cases of various forms of arthritis treated with gold salts[3-9]. The cases differed widely in the types of arthritis treated, the dosage and form of gold used, and the incidence of complications. But it is extremely significant that of a total of 956 cases of rheumatoid arthritis treated with gold salts, six studies, representing 947 cases, reported good results, ranging from moderate improvement to complete arrest, in from 80 to 92 per cent of this series; improvement was noted in 820 of the total 956 cases, an average of 85 per cent. The single adverse report dealt with only 9 cases, and even here some benefit was admitted. Most of the reports are by men of wide experience in the treatment of arthritis and who have seen other forms of therapy tried and discarded. Key,[4] in an unusually valuable report, states that all the previous forms of treatment tried in the Arthritic Clinic of Washington University have been disappointing. He adds: ". . . it is our opinion that gold therapy has definitely ameliorated the course of the disease in the majority of our patients with atrophic arthritis in whom it has been given a fair trial, and this is true regardless of the duration of the disease." Copeman and Tegner[6] state: "It is our opinion that gold is the medication of choice in early cases of the rheumatoid arthritis type when the sedimentation-rate is raised."

Hartfall and Garland[5] state: ". . . gold is the best single form of treatment in rheumatoid arthritis."

Crosby[8] states: "I have, however, at present no doubt that this form of treatment is quite the most potent now available."

The use of gold salts in the treatment of arthritis has been greatly restricted by a fear of toxic reactions. This is quite proper, for gold is a potentially dangerous drug. It is a heavy metal and consequently is cumulative in its action. Toxic effects in the skin may lead to exfoliative dermatitis; in the liver to every grade of hepatitis, even to acute yellow atrophy; in the bone marrow to agranulocytosis, purpura, or aplastic anemia; and in the kidneys to albuminuria and degenerative changes in the tubules and Bowman's capsule. It will be noted at once that these toxic effects are exactly comparable to those noted in the arsenical treatment of syphilis. The fact that they may occur must be remembered, and indiscriminate use of the drug is to be avoided. On the other hand, the risks entailed must not be over-emphasized. We are dealing with a progressive and

potentially crippling disease, and any method of treatment which offers 85 per cent good results and from 10 to 20 per cent complete cures is worthy of consideration. Severe toxic reactions are relatively uncommon. In the series of 956 cases, fourteen severe reactions were reported (1.5 per cent). These consisted of two cases of acute yellow atrophy, three of purpura, two of agranulocytosis, six of exfoliative dermatitis, and one of stomatitis. Seven of these reactions were fatal. Milder reactions, consisting of transient skin rashes, albuminuria, diarrhea, and chills or fever, occur in about 40 per cent of all cases.

Certain precautions may be taken to prevent or minimize these reactions, many of which are due to hypersensitivity rather than actual toxicity. A patch test[11, 12] with gold sodium thiosulfate will show those who are hypersensitive. A majority of the reactions occur in the group of patients with positive patch tests, although since many of those with positive skin tests never have any reaction, the test is of little clinical value. Vitamin C, as ascorbic acid, 150 mg. daily, seems to decrease the incidence of purpuric phenomena, and nicotinic acid has a beneficial effect on the dermal lesions.

With these considerations in mind, the use of gold salts was introduced early in 1939 at the Arthritis Clinic of Milwaukee County Dispensary. Its use was restricted to patients with chronic active rheumatoid arthritis who, in a previous period of observation, failed to respond to more conservative forms of therapy. The preparation used was gold sodium thiosulfate, Merck, given intravenously in weekly doses ranging from 10 to 100 mg., until a total of 1 Gm. was given. This treatment usually required about four months, and a second course was given if indicated. It was usually noted that on about the third or fourth injection increased joint pain was noted, and improvement usually began after seven or eight injections. The patients who showed the most marked exacerbation of joint pain following injection were, in general, those who ultimately experienced the greatest benefit, an observation previously made by others.

Sixteen patients for whom gold therapy was thought to be indicated, on the basis of the above criteria, were used for this report. One patient, an old "burned out" case of rheumatoid arthritis, was not benefited. Benefit is not to be expected in this type of case. A second patient developed fever, headache, and dizziness after four injections. Spinal fluid showed a 3 plus globulin; no other neurologic findings were noted. The relationship of this episode to the injections is questionable, though it possibly may have been a toxic encephalitis.

One patient developed a severe edema of the lips after a single injection, and it was thought inadvisable to continue the treatment. Another, noting no benefit after two injections, refused to continue the treatment.

Of the remaining 12 patients, 9 showed marked improvement, consisting of decreased joint swelling, increased mobility, decreased sedimentation rate, and almost complete absence of pain. The last was the earliest and most constant sign of improvement. Patients who previously required large doses of analgesics to control pain frequently were able to omit their use entirely or to take them only occasionally.

Two patients showed only slight improvement consisting chiefly of gain in weight and less fatigue. In 1 patient emotional instability and vasomotor phenomena were particularly marked with frequent episodes of paroxysmal tachycardia not related to the injections. After one year of observation, he shows no sign of the disease, has returned to work, and feels completely well. The other patient was showing definite improvement, but severe pruritus and an erythematous skin rash forced discontinuation of treatment after only six injections.

Toxic reactions, though of frequent occurrence in this series, as shown in Table I, were usually of a mild and transient nature. In only 2 patients were they considered sufficiently severe to require cessation of the treatment. In both instances they occurred early in the course of treatment and were clearly manifestations of hypersensitivity rather than of cumulative toxicity. One patient who is considered apparently cured showed no toxic reactions whatever, thus

TABLE I

Case No.	Sex	Age	Duration Years	Dosage Grams	Reactions	Sedimentation Rate (% of Normal)		Result
						Initial	Final	
1	F	29	2	0.9	Skin Rash Albuminuria Nose Bleeds	80	92	Marked Improvement
2	F	33	1	2.3	Albuminuria	90	100	Marked Improvement
3	F	22	7	1.5	Albuminuria	52	73	Marked Improvement
4	M	50	10	1.1	Albuminuria Chill, Pruritus	76	91	Marked Improvement
5	F	56	9	1.8	Albuminuria Skin Rash	89	95	Marked Improvement
6	M	40	1	1.5	None	88	98	Marked Improvement
7	M	39	2	0.4	Toxic Encephalitis (?)	------	------	Improved
8	M	43	5	0.6	Loss of Taste	------	------	Unimproved
9	F	38	2	0.9	Pruritus	52	82	Marked Improvement
10	F	20	1	1.1	None	82	91	Apparently Cured
11	F	41	2	2.1	Pruritus	75	85	Marked Improvement
12	M	19	2	2.5	Sweats	62	62	Unimproved
13	F	40	8	2.2	Stomatitis	60 mm 1 hr.	27 mm 1 hr.	Marked Improvement
14	F	18	2	0.15	Exfoliative Dermatitis (Mild)	125 mm 1 hr.	------	Improved
15	F	38	8	0.035	None	------	------	Unimproved
16	F	40	2	0.010	Edema of Lips	------	------	Unimproved

showing that the production of a reaction is not essential for a successful outcome.

Summary

1. Gold salts give better results in the treatment of rheumatoid arthritis than any other drug known today.

2. The use of gold salts is not indicated in other forms of arthritis and should be restricted to patients who have failed to improve on more conservative forms of therapy.

3. In patients selected for treatment close observation is necessary, together with weekly urinalyses and frequent blood counts, to detect the earliest evidences of toxic reactions.

4. Severe toxic reactions can be largely eliminated by these precautions, combined with the use of ascorbic acid and nicotinic acid and by restricting dosage to the lower therapeutic levels.

5. In all cases improvement in the clinical picture was associated with a decreased sedimentation rate.

6. Gold is not a specific and should not be expected to correct pre-existing cartilage destruction or deformities. It should be used only as an adjunct to the well established principles of diet, rest, physiotherapy and orthopedic correction which are the foundation of our therapy in this disease.

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Once Again—A "Deal"

IN THE July, 1941, issue of *The Journal* there appeared an article entitled "Physicians Offered a 'Deal.'" During the last few weeks this same card, again quoted below, was circulated among Wisconsin physicians:

"Dear Doctor: I would like to enter into an agreement with you, requiring your full time service away from your office. Attractive opportunity and fine remuneration. Office space is provided. This is a permanent arrangement. The proposition is in WISCONSIN. If you are interested, wire at once, giving your phone number, so that I can call you OR PHONE ME AT MONROE 2148—CHICAGO.

B. SHERMAN
1148 W. Chicago Ave.
Chicago, Ill.

The July article quoted excerpts from *The Journal of the American Medical Association* of February 15, 1941, on page 597, and which we feel should be quoted again:

"A check of the address indicated that its occupant is the Ritholz Optical Company. The Bureau of Investigation first dealt with the Ritholz optical concerns in an article in THE JOURNAL, July 25, 1925. Ten years later, in the July 6, 1935 issue, the Bureau reported, under the title 'The Ritholz Frauds,' a post office fraud order issued against the concern. Nine different trade styles were listed in this article, although not all of them were named specifically in the fraud order, some of them apparently being local concerns not employing the mails; namely, 'Dr. Ritholz Optical Co., Inc.' 'Dr. Ritholz Optical Co.' and 'Ritholz Optical Co.' This article also called attention to the fact that the energetic action on the part of the Chicago Better Business Bureau had resulted in barring the facilities of Chicago newspapers and radio stations to these stores. Subsequently the Ritholz concern agreed to advertise in accordance with the standard practice of optometrists, and the Better Business Bureau announced this in its Bulletin. Later THE JOURNAL carried reports of two law suits involving the National Optical Stores and Benjamin D. Ritholz. The first of these referred to the case of *Ritholz et al. v. North Carolina State Board of Examiners in Optometry et al.*, 18 F. Supp. 409, which was abstracted in THE JOURNAL, Dec. 11, 1937, page 2015; the second was that of *Ezell et al. v. Ritholz et al.* (S.C.), 198 S. E. 419, which was abstracted in THE JOURNAL, July 1, 1939, page 88.

"In 1934 the Federal Trade Commission issued an order against Benjamin D. Ritholz of Chicago, doing business under the names Chicago Dentists and Chicago Dental House, Inc., in connection with the promotion of a dental plate in interstate commerce. In 1937, subsequent to the appearance of the fraud order, the Federal Trade Commission issued a complaint against the National Optical Stores and Dr. Ritholz Optical Company for their activities in connection with the promotion of spectacles. Subsequently the Post Office Department issued a fraud order against the Chicago Dentists, Chicago Dental House and International Dental House for using the mails in the promotion of dental plates. In this fraud order Mr. Benjamin D. Ritholz is mentioned as 'one of the proprietors of the above named concerns.'

"By engaging repeatedly in such practices, these concerns have shown their total disregard for the welfare of the American people and their desire to make a profit at the expense of the eyesight of the citizens of this country. Their effrontery in attempting to engage unsuspecting physicians to promote their activities is astounding. An ethical physician would not give the slightest consideration to alining himself with such an outfit."

Comments on Treatment

Editor—A. J. QUICK, M. D., Marquette University, Milwaukee

The Miller-Abbott Tube

The Miller–Abbott tube is an important recent contribution to the handling of serious intestinal conditions such as obstruction and paralytic ileus. It consists of a combination of two rubber tubes, or of a tube with a double lumen (see Figure 1). The tube with the larger lumen serves for aspiration, while the other is used for inflating a small rubber balloon which surrounds its distal end. The effectiveness of the tube depends on two factors: (1) the aspiration of gas and fluid from the distended gut allows the intestinal wall to contract thereby restoring tonus and the normal propulsive movements, and (2) the inflated balloon is grasped by the peristaltic waves and carried forward into the small intestines thereby advancing the tube to the site of the obstruction. The relief of the distention brings about a marked alleviation of pain and discomfort and in some instances is sufficient to overcome the obstruction. The tube has been successfully employed in paralytic ileus for localizing the point of obstruction and even for characterizing the nature of the obstruction by combining the technic with a small amount of barium sulfate. After an intestinal operation, it can be employed to reduce the tension on the sutures by preventing distention. Another important use of the Miller–Abbott tube is to supply fluid and salt thereby restoring the fluid and mineral balance.

The tube has certain disadvantages and limitations. It requires a certain amount of technical skill to pass it into the duodenum, and at times this can become a very difficult task. Since it takes several hours before the tube reaches the jejunum or ileum, the procedure is unsuitable for acute conditions requiring immediate treatment. Thus, strangulated obstruction and other conditions in which gangrene is encountered require prompt intervention, and it would not only be hazardous but futile to depend on the Miller–Abbott tube. It is not suitable for abnormalities in the colon.

The introduction of the tube into the stomach is relatively easy. The balloon is deflated, the tube lubricated with mineral oil and passed through the patient's nose. A few

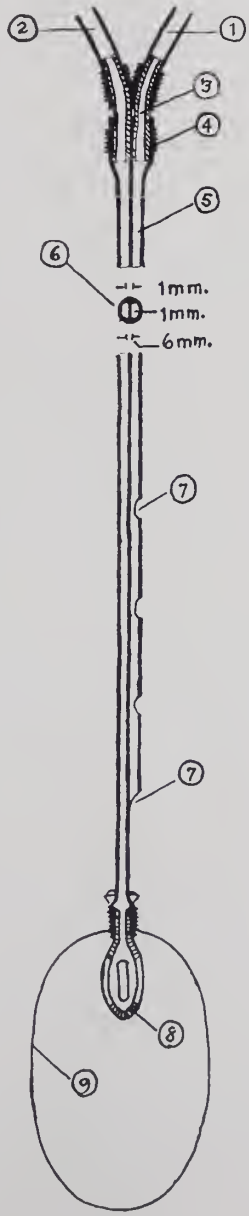


Fig. 1.—Longitudinal sections of double-lumened rubber tube. The lumen on the right side is referred to as "A" and the other lumen as "B." 1, a proximal tube communicating with "A"; 2, one communicating with "B" (different colors); 3, a brass cannula for making the connection between a lumen of double tube and proximal single tube; 4, thread holding two brass tubes in place; 5, outer wall of double-lumened tube; 6, transverse section of tube; 7, opening into lumen "A"; 8, Rehfuss bucket; 9, rubber bag; (condom or finger cot).

swallows of water facilitate the passage into the stomach. The difficult task is passing the tube through the pylorus. The patient should lie on his right side, and after the tube is within four inches of the pylorus, several hours should be allowed before advancing it further. About one inch is introduced every thirty minutes until one foot more is swallowed. After the tube is in the duodenum, the balloon is inflated and passed at the rate of six inches every thirty minutes. During these procedures suction is maintained, and the lumen is flushed at least every hour with water to prevent plugging. The course of the tube at various stages should be checked with the fluoroscope.

The passing of feces and gas by rectum indicates that the tube can be removed. It is advisable before withdrawal to discontinue suction in order to determine whether the intestines can handle fluids and solid matter without again becoming obstructed. The tube can be withdrawn at the rate of one to two feet per hour.

In summary, the Miller–Abbott tube has become a valuable adjunct to the surgeon's methods of handling intestinal conditions. Diagnostic acumen must determine when and when not to employ the tube, and roentgenography should be used to follow the result of therapy, particularly in mechanical obstruction. If decompression does not occur in twenty-four hours, surgical intervention is indicated. It is safe to predict that the usefulness of the Miller–Abbott tube will increase as the profession becomes more familiar and experienced with this instrument. A. J. Q.

Author's Note: My thanks are due to Mr. Carroll R. Olson, one of my students, who collaborated with me in the writing of this article.

MANY A DIVIDEND

■ *The Wisconsin Medical Journal* is carefully planned to be of particular value to members of the State Medical Society. Are you getting full value from it?

The December Blue Book issue, a copy of which has been sent to all new members, as well as to the membership at the close of 1941, contains innumerable articles of daily importance to the busy practitioner. It should be on his desk at all times, and his office staff should become thoroughly acquainted with its contents. Poor relief, office lease provisions, state health services and regulations, the compensation law, material relating to the narcotic laws—these and many another are discussed in detail.

The June issue of *The Journal* carried with it a special supplement on "Health and Food." Outstanding authorities contributed to its columns. Is your copy on the waiting room table? Extra copies are still available, although some 8,000 have now been distributed, one request coming all the way from Australia.

Not long ago *The Journal* carried as a special supplement a brochure on "Health Achievements in Wisconsin." Simultaneously the Society announced the availability of a projection lantern and a film strip on the same subject, so that its members might use the material on appropriate occasions. A health education project—have you used it?

The August issue of *The Journal* contained a placard entitled ". . . In Time of War . . ." as well as an interview with the state consultant of the Procurement and Assignment Service for Physicians cautioning those contemplating early military service from making premature announcements to that effect. Copies of both the placard and the interview were sent hospital superintendents. Is your copy of the placard posted?

The cooperative efforts of *The Journal* and authorities of the University of Wisconsin developed the so-called "packet service" of material on particular scientific subjects. It is doubtless one of the most outstanding services now available in the country. Are you using it when the occasion demands?

To those about to enter military service, a special article has been prepared for this issue of *The Journal*—that on war-risk insurance.

Each issue contains material of similar importance. Scan *The Journal* each month as it comes to your desk,—become generally acquainted with its contents, then lay it aside until you have time to review it carefully. It will pay many a dividend.

THE NATION AT WAR

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Life Insurance and the Physician in Service

IN COMMON with other professional groups, physicians depend very largely upon their life insurance programs both for their personal independence in later years and for the financial self-sufficiency of their families. Accordingly, the subject of insurance, as it is affected by military service, is a matter of very real importance to the profession. The problem has two aspects. The first is the provision made for existing personal life insurance programs. The second is the provision made by the government for carrying additional coverage for the benefit of those in service. The subject will be considered in that order.

I. RELIEF AS TO PERSONAL INSURANCE PROGRAMS

War Risks Exclusion Clauses

Practically all private life insurance policies which have been written since the fall of 1941 have carried a so-called "war risks exclusion" clause. This ordinarily takes one of three forms. It may provide that the insurance company shall not be liable for payment if death occurs while the insured is in the armed forces of the government in time of war. Still another type of clause is that providing that the insurance company shall not be liable for payment in case of death which occurs as a result or in consequence of military service. The third common type of clause provides that the company shall not be liable for death occurring while the insured person is "engaged" in military service.

It is clear that in the case of policies which contain war risks exclusion clauses the liability of the insurance company depends both on the wording of the clause and on the cause of death. Some companies will insure against war risks but in so doing exact an additional premium which more than doubles the ordinary cost of such policy. This type of limitation has the effect of rendering much insurance written for a man of military age of doubtful potential value to his family or estate.

Still another reason why physicians of military age view with some concern their personal life insurance programs at this time is the uncertainty that they will be financially able to maintain such programs in force during their period in the armed service of the country. The severe reduction in income which attends the giving up of an active medical practice makes it inevitable that a substantial portion of an individual life insurance program can be carried only by borrowing, or may even have to lapse.

Relief for Service Men

The Soldiers' and Sailors' Civil Relief Act of 1940 affords only limited relief in the matter of personal life insurance. The Act in effect gives to persons in military service a moratorium on premiums on life insurance which is not in excess of $5,000. However, it is important to note that this provision is applicable only to policies taken out before the date of approval of the Act, which was October 17, 1940, or on which premiums were paid not less than thirty days before entry into active service. It is also important to note that the Act does not apply to policies on which premiums are unpaid for more than one year, or against which a policy loan or other indebtedness is outstanding equal to 50 per cent of the cash surrender value.

If a physician had only a single policy on his life, and that were for $10,000, the fed-

eral government may compel the insurance company to break that into two $5,000 policies, and to maintain one of those policies in force under the terms of this statute.

The policies are to be kept in force through the Veterans Administration to which an interested physician should make application after entering service. The original application by the insured physician to come under the benefits of the Act is sent to the insurance company and a copy to the Veterans Administration. The insurance company is held to have assented to a moratorium on premiums by receiving and filing the application. The application is known as "Veterans Administration Insurance (Civil Relief) Form No. 380." Under the operation of these provisions of the 1940 Act no policy which has not lapsed for nonpayment of premium before the commencement of military service by the insured physician or other person, and which has been brought within the benefits of the Act, shall lapse or be forfeited for nonpayment of premium during the period of such service, or during one year after the expiration of such period.

The Veterans Administration is to issue interest-bearing certificates of the U. S. Treasury to the insurance company to cover all premiums which are deferred under the provisions of the Act, and the government will give a first lien on any policy receiving the benefits of the Act.

In summary, it should be said that the Act is excellent in its intent and machinery except for the limitation on the amount. It does permit a physician who cannot continue all of his insurance in force to carry the more modest part of the load in the less expensive types of coverage, and to invoke the benefits of the Act as to $5,000 in additional coverage of a more expensive type which would otherwise have to lapse for nonpayment of premiums.

II. NATIONAL SERVICE LIFE INSURANCE

Introduction

To provide life insurance in amounts from $1,000 to $10,000 for persons in the active service of the armed forces of the United States there was enacted two years ago a statute known as the "National Service Life Insurance Act of 1940." This was enacted in anticipation of the perils incident to service in our armed forces either under the Selective Service Act or during a state of actual war, it being appreciated it would be impossible for men in service to procure adequate life insurance from private carriers except at extremely high rates. An outstanding difference between the War Risk Insurance Act of 1917 and the 1940 Act is that the former provides for benefit payments in the event of total and permanent disability, as well as in the case of death, whereas the recent Act does not. The 1940 Act provides only for life insurance. However, it does provide that payment of premiums is waived during the continued total disability of a service man which began subsequent to the effective date of his insurance, and which continued for six consecutive months or more prior to the insured's sixtieth birthday.

A 1941 amendment provides automatic insurance, if no government insurance had been in force, against death in line of duty in active service in an aggregate amount of $5,000 where such death occurred between October 8, 1940 and April 19, 1942. A 1942 amendment goes even farther by providing in the case of men in service who have in fact not applied for insurance, that $5,000 shall be deemed to be in force, with waiver of premium, during a period of total disability as a result of injury or disease incurred in line of duty, where such disability continues without interruption for six months, such premium waiver to continue until six months after total disability ceases, so long as such date is not later than April 21, 1943.

A second 1942 amendment places in force $5,000 in insurance on those who did not have that much in force under the National Service Life Insurance Act, or under the prior acts of 1917, or 1924, in all cases of men subjected to capture, seige, or isolation between December 7, 1941 and April 20, 1942. Premiums on such insurance shall be waived during the period that such insured person remains captive, besieged, or isolated, and for six months thereafter. The humanitarian purpose and intent of these amendments are self-evident.

Persons Insurable

Any person in active service in the land or naval services of the United States, including the Coast Guard, is entitled to apply for national life insurance if such person is serving under orders to active duty not limited to a period of less than thirty-one days.

Any person in active service on December 20, 1941 could apply for insurance without the requirement of a medical examination up to April 19, 1942, but after that date would have to pass a medical examination. Persons entering active service after December 20, 1941, have 120 days within which to apply for national service life insurance without medical examination.

It is strongly urged that a physician apply for insurance as soon as he enters upon active duty. It is uncertain whether he has a right to increase or decrease the amount of insurance originally asked for, as the Act is silent on this question. However, there are known instances where increases have been allowed, but this is not true of decreases. The insurance becomes effective upon the date specified in the application but not later than the first day of the calendar month following the date of application.

It is prudent to have the insurance take effect immediately since the government is not liable in the case of death which intervenes between the date of application and the date the insurance was to take effect, if those dates are not the same. Thus, if a physician applied for insurance on October 1 to be effective November 1, and died October 15, there would be no liability on the part of the government. If, however, he had applied September 1 and had stipulated that the insurance take effect as of that day, the government would be liable were his death to occur on September 15.

Beneficiaries

If no beneficiary is designated in the policy, the proceeds are payable in the following order to the following person or group surviving the deceased insured: widow, child or children, parent or parents, brothers and sisters. If none of the above persons or groups survive, the government will make no payment. The insurance is not payable to the estate of the insured person in such a situation as was true under the 1917 Act.

If the insured person desires to designate a beneficiary he is limited to the above classes and to stepchildren, to illegitimate children, and to relatives or others who have given him a home or otherwise taken the place of natural parents.

It is uncertain whether insurance under the 1940 Act is payable to an adopted child or to adopted brothers and sisters, stepbrothers and stepsisters, and sisters and brothers of the half-blood. Under a 1942 amendment a father or mother by adoption may expressly be included as a beneficiary. The information booklet issued by the Veterans Administration, dated August, 1941, and designated as "Insurance Form 398," states that an adopted child may be a beneficiary. While this is a desirable administrative ruling, it is not certain that the courts will so hold under the wording of the Act.

The service man carrying national service life insurance has the right at all times to change the beneficiary or beneficiaries without the consent of the latter. Under the Act the beneficiary has no vested or property rights in the proceeds of the insurance, even under a contract whereby the insured agrees not to change the beneficiary.

Cost and Conversion of Service Insurance

The cost of national service life insurance varies between 67 cents per month per $1,000 for a man of twenty-four and $1.27 per month per $1,000 for a man of fifty. Since a physician going into service will seldom be less than twenty-four, and few of them will be more than fifty these examples of monthly costs should suffice to indicate the range. The rates rise rather rapidly for men over fifty.

This service insurance is five year, level premium, term insurance, without any cash value during the term period. The privilege of conversion to policies of national service life insurance on ordinary life, twenty payment life, or thirty payment life plan is permitted any time between the end of the first and prior to the expiration of the fifth year

of the term. Unless converted on or before expiration of the five year term period, the insurance ceases and terminates on the latter date. The ordinary life policy will be payable throughout the lifetime of the insured, as is true of insurance with private companies. A twenty payment life contract pays up the policy after twenty years, and a thirty payment life contract does likewise after thirty years.

Payment of Benefits

The proceeds of a national service life insurance policy are not paid or payable in their face amount at the time of the death of the assured but are distributed in equal monthly installments over a period of ten or twenty years according to the age of the beneficiary. If the beneficiary to whom payment is first made is under thirty years of age at the time of death of the insured, payment shall be made over a twenty year period in 240 equal monthly installments at the rate of $5.51 for each $1,000 of insurance.

If the beneficiary to whom payment is first made is thirty or more years of age at the date of death of the insured, payment is made over a ten year period in 120 equal monthly installments in accordance with a schedule based upon the American experience table of mortality, with interest at 3 per cent. The amounts so paid vary from $3.97 a month per $1,000 of insurance in the case of a beneficiary thirty years of age, to $9.61 per $1,000 per month in the case of a beneficiary eighty-five years of age.

Upon proof of death of the first beneficiary, monthly installments shall thereafter be made in the same amount to the person or persons next entitled to receive the proceeds, until all of the installments shall have been paid. Neither the statute nor the regulations thus far disclose what is to be done if there are two or more persons in one class, one of whom is under thirty and one over thirty, when the first monthly installment is paid but this will be worked out in time.

Policies Governing Initial Appointment of Medical Officers*

THE Surgeon General of the Army published detailed information concerning policies governing the initial appointment of physicians as medical officers on April 23, 1942. Necessary changes are given wide publicity, at his request, in order that the individual applicants, and all concerned in the procurement of medical officers, may know the status of such appointments.

The current military program provides for a definite number of position vacancies in the different grades. The number of such positions must necessarily determine the promotion of officers already on duty and, in addition, the appointment of new officers from civilian life. Such appointments are limited to qualified physicians required to fill the position vacancies for which no equally well qualified medical officers are available. Such positions calling for an increase in grade should as far as possible be filled by promotion of those already in the service and not by new appointments.

If this policy is not followed, it would definitely penalize a large number of well qualified lieutenants and captains already on duty by blocking their promotions which have been earned by hard work. In view of these facts it has been deemed necessary to raise the standards of training and experience for appointment in grades above that of first lieutenant.

With this in view, the Surgeon General has announced the following policy, which will govern action to be taken on all applicants after Sept. 15, 1942:

All appointments will be recommended in the grade of first lieutenant with the following exceptions:

Captain.—1. Eligible applicants between the ages of 37 and 45 will be considered for appointment in the grade of captain by rea-

* Reprinted from *The Journal of the American Medical Association,* issue of September 12, 1942.

son of their age and general unclassified medical training and experience.

2. Below the age of 37 and above the age of 32, consideration for appointment in the grade of captain will be given to applicants who meet all of the following minimum requirements:

(a) Graduation from an approved medical school.

(b) Internship of not less than one year, preferably of the rotating type.

(c) Special training consisting of three years' residency in a recognized specialty.

(d) An additional period of not less than two years of study and/or practice limited to the specialty.

3. Eligible applicants who previously held commissions in the grade of captain in the Medical Corps (Regular Army, National Guard of the United States, or Officers Reserve Corps) may be considered for appointment in that grade provided they have not passed the age of 45 years.

Major.—1. Eligible applicants between the ages of 37 and 55 may be considered for appointment under the following conditions:

(a) Graduation from an approved school.

(b) Internship of not less than one year, preferably of the rotating type.

(c) Special training consisting of three years' residency in a recognized specialty.

(d) An additional period of not less than seven years of study and/or practice limited to the specialty.

(e) The existence of appropriate position vacancies.

(f) Additional training of a special nature of value to the military service, in lieu of the foregoing.

2. Applicants previously commissioned as majors in the medical Corps (Regular Army, National Guard of the United States or Officers Reserve Corps) whose training and experience qualify them for appropriate assignments may be considered for appointment in the grade of major provided they have not passed the age of 55.

Lieutenant Colonel and Colonel.—In view of the small number of assignment vacancies for individuals of such grade, and the large number of reserve officers of these grades who are being called to duty, such appointments will be limited. Wherever possible, promotion of qualified officers on duty will be utilized to fill the position vacancies.

Much misunderstanding has arisen concerning recognition by specialty boards and membership in specialty groups. It will be noted that mention is not made of these in the preceding paragraphs. This is due to the variation in requirements of the different boards and organizations. Membership and recognition are definite factors in determining the professional background of the individual but are not the deciding factors, as so many physicians have been led to believe.

The action of the grading board, established by the Surgeon General in his office, is final in tendering initial appointments. Proper consideration must be given such factors as age, position vacancies, the functions of command and original assignments. All questionable initial grades are decided by this board. Owing to the lack of time, no reconsideration can be given.

There are in the age group 24–45 more than a sufficient number of eligible qualified physicians to meet the Medical Department requirements. It is on this age group that the Congress has imposed a definite obligation of military service through the medium of the Selective Service Act. The physicians in this group are ones needed now for active duty. The requirements are immediate and imperative. Applicants beyond 45 years may be considered for appointment only if they possess special qualifications for assignment to positions appropriate to the grade of major or above.

"KEEP 'EM WORKING"

The Council on Scientific Work announces the first postgraduate industrial medical and surgical clinic to be presented on Tuesday, November 17. See program in this issue.

"KEEP 'EM WORKING"

Lieutenant Colonel Sam F. Seeley Transferred From Procurement and Assignment Service to Active Military Duty

THE Directing Board of the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians, has formally expressed its appreciation of the services rendered by Colonel Sam F. Seeley, who has been transferred to military duty. Following is the text of the resolution adopted:

"The transfer of Lieutenant Colonel Sam F. Seeley from his connection with the Procurement and Assignment Service to active military duty causes a great loss. Colonel Seeley who has acted as Executive Officer since the beginning of this Service has been transferred to military duty, which is in keeping with the policy recently adopted by the War Department. His training and experience with the Medical Corps of the Army in his professional capacity amply justifies such a step.

"The Directing Board of the Procurement and Assignment Service wishes to take this opportunity of expressing to the Surgeon General of the United States Army its very deep appreciation for the valuable service which Colonel Seeley has rendered during its period of organization and functions.

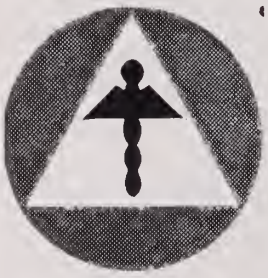
"The Directing Board expresses to Colonel Seeley its deep appreciation for the great sacrifice which he has made in dislocating himself from actual military duty to serve with us in an executive capacity. He has been most unselfish, and has given unstintingly of his time, energy, and patience in helping to solve many of the problems connected with the functioning of the Procurement and Assignment Service. He has not only labored faithfully at our office in Washington, but he has traveled over the United States contacting many of his professional conferees and explaining to them the purpose for which the Procurement and Assignment Service was organized. His services have been most valuable and have helped to take us a long way in accomplishing the objectives for which it was created.

"The Directing Board expresses to Colonel Seeley its gratitude and thanks for his unselfish devotion to the organization of the Procurement and Assignment Service and wishes for him the greatest success in his new assignment.

"FRANK H. LAHEY, M. D., *Chairman*
HARVEY B. STONE, M. D.
HAROLD S. DIEHL, M. D.
JAMES E. PAULLIN, M. D.
C. WILLARD CAMALIER, D. D. S."

Emergency Medical Service Insignia

Members of the Society who are serving as county chiefs of Emergency Medical Service, or who are serving in other capacities in Emergency Medical Service, may obtain Medical Corps insignia through their county council of defense.



Of current importance to physicians during blackout trials are the large emergency "E's" which are fastened to the automobile by the so-called decalcomania or transfer process. This emblem is made from a material which absorbs light during the day and reflects it at night. This makes it possible for physicians to move from one location to another during blackouts. Other insignia available are arm bands, lapel buttons, and decalcomanias for the side of the car.

Requests for Emergency Medical Service insignia should be routed through the county councils of defense.

"KEEP 'EM WORKING"

An outstanding scientific program will be presented at the first postgraduate industrial medical and surgical clinic to be held in Milwaukee on November 17. See program in this issue.

"KEEP 'EM WORKING"

THE WISCONSIN MEDICAL JOURNAL

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Annual Subscription--------Three Dollars-Fifty Cents Single Copies--------Fifty Cents

Advertising Representative: Cooperative Medical Advertising Bureau, 535 North Dearborn St., Chicago, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, Madison

Volume 41 OCTOBER, 1942 Number 10

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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« « « EDITORIAL » » »

". . . That the Profession Shall Become More Capable . . ."

IT HAS been said that of the virtues of organization, that which is the strongest stems from invigorating companionship and discussion. Yet in the face of the uncertainties that lie ahead, it has occurred to many of us that time and effort must be placed on the ration list along with the more tangible commodities of life. Reflection will, perhaps, temper the firmness of that thought when we come to apply it to specific matters.

It is akin to a platitude to state that a major part of the armamentarium of progress and success in the medical world lies in the free exchange of scientific knowledge and findings—for strength and truth alike are the development of melded opinions and the work of all. To this end, then, it appears to be the clear obligations of the various medical organizations to hold firmly to their responsibilities. During the winter months, it becomes their opportunity to stimulate discussion of medical problems, to execute the same forward and valuable programs that characterize a profession. Local meetings must continue, warped, perhaps, to the needs of the times and the resources available, but nonetheless important in the professional sense.

The ramparts to be held at home are no less important to the war effort than those to be held at the front lines. Absenteeism in industry, school health, general community health, civilian morale,—all these and many more are on the calendar during the winter ahead.

F. E. BUTLER, M. D.
President, State Medical Society of Wisconsin

Dr. F. E. Butler, Menomonie, the new president of the State Medical Society of Wisconsin, was born at Random Lake, Wisconsin, on August 12, 1880. He received his preliminary education at St. John's Military Academy, Delafield, Wisconsin, and was graduated from Milwaukee Medical College, in 1903.

Dr. Butler has practiced at Menomonie since his graduation from medical school. He is a member of the American College of Surgeons and a former councilor of the Tenth District of the State Medical Society.

Almost 2,000 Attend One Hundred First Anniversary Meeting; Dr. R. M. Kurten, Racine, Named President-Elect

IN ONE of the largest meetings ever held by the State Medical Society of Wisconsin, nearly 50 per cent of the entire membership registered in Milwaukee on September 14, 15 and 16, making the membership registration 150 over that at the Centennial Meeting. Three hundred eighty-five persons attended the annual banquet, and over 1,100 were registered at the round-table discussions.

Despite the fact that many members of the Society have been called into military service and others have assumed heavier burdens in their local communities, this year's registration surpassed that of the last few years. A comparative breakdown of the attendance for 1940, 1941, and 1942 is as follows:

COMPARISON OF REGISTRATION AT ANNUAL MEETINGS

Group	1940	1941	1942
Physician Members	1199	972	1089
Physician Guests	105	156	126
Internes and Medical Students	106	156	469
Exhibitors and Miscellaneous Guests	285	470	300
Total Registration	1695	1754	1984

New Officers Named

In its concluding session on Tuesday morning, the House of Delegates named as officers for the ensuing year, the following:

President-elect—Dr. R. M. Kurten, Racine
Speaker of the House—Dr. Charles Fidler, Milwaukee
Vice-speaker—Dr. P. R. Minahan, Green Bay
Delegates to the American Medical Association—Drs. S. E. Gavin, Fond du Lac, and J. C. Sargent, Milwaukee (now in service)
Alternate delegates to the American Medical Association—Drs. L. O. Simenstad, Osceola, and A. E. Rector, Appleton

The following committee appointments were made by President Butler to replace those whose terms expired at this session:

To the Committee on Cancer
Dr. J. W. McGill, Superior, reappointed
Dr. G. E. Eck, Lake Mills, reappointed
Dr. D. J. Twohig, Fond du Lac, reappointed
Dr. T. E. Malloy, Random Lake
Dr. Charles Fidler, Milwaukee, to continue as chairman

To the Advisory Committee on Care of Crippled Children
Dr. H. A. Sincock, Superior, reappointed
Dr. J. B. MacLaren, Appleton, to continue as chairman

To the Committee on Coordination of Medical Services
Dr. S. E. Gavin, Fond du Lac, reappointed
Dr. C. O. Vingom, Madison, to continue as chairman

To the Committee on Goiter
Dr. A. S. Jackson, Madison, to continue as chairman

To the Committee on Grievances
Dr. A. J. Patek, Milwaukee, reappointed
Dr. A. E. Rector, Appleton, appointed to serve until 1943 as an alternate member of that committee in view of the fact that one of its members is now in service, and Dr. Rector has been designated as chairman

To the Committee on Health and Public Instruction
Dr. G. W. Krahn, Oconto Falls
Dr. W. J. Egan, Milwaukee, to serve as chairman

To the Committee on Hospital Relations
Dr. W. H. Jaeschke, Fond du Lac
Dr. J. E. Habbe, Milwaukee, reappointed and to serve as chairman

To the Committee on Industrial Health
Dr. Gunnar Gundersen, La Crosse, to serve as chairman

To the Committee on Maternal and Child Welfare
Dr. J. W. Harris, Madison, reappointed
Dr. A. C. Radloff, Plymouth, to serve as chairman

To the Committee on Medical Economics and Voluntary Sickness Insurance—To this committee, which has just been organized by the House of Delegates, the following members have been appointed:
Dr. D. H. Witte, Milwaukee, chairman
Dr. F. G. Anderson, Eau Claire
Dr. L. D. Quigley, Green Bay
Dr. T. A. Leonard, Madison
Dr. Robert Krohn, Black River Falls
Dr. A. C. Taylor, Appleton

To the Committee on Medical Education and Hospitals
Dr. F. D. Murphy, Milwaukee, reappointed and to serve as chairman

PAST-PRESIDENTS' LUNCHEON

Seated (left to right): Drs. M. A. McGarty, La Crosse, 1921; J. F. Smith, Wausau, 1926; B. M. Caples, Waukesha, 1911; F. E. Butler, Menomonie, 1943; S. E. Gavin, Fond du Lac, 1937; O. A. Fiedler, Sheboygan, 1932.

Seated: A. E. Rector, Appleton, 1939; Gunnar Gundersen, La Crosse, 1942; A. J. Patek, Milwaukee, 1913; R. P. Sproule, Milwaukee, 1941.

To the Committee on Mental Hygiene and Institutional Care

Dr. B. J. Hughes, Winnebago, appointed

Dr. H. H. Christofferson, Colby, to continue as chairman

To the Committee on Public Policy

Dr. C. A. Dawson, River Falls, reappointed, and to continue as chairman

To the Council on Scientific Work

Dr. C. D. Neidhold, Appleton

To the Committee on Tuberculosis and Chest Diseases

Dr. A. A. Pleyte, Milwaukee, reappointed

Dr. L. O. Simenstad, Osceola, to serve as chairman

To the Advisory Committee on Visual and Hearing Defects

Dr. F. S. Cook, Eau Claire, reappointed and to serve as chairman

Delegate Action

All sessions of the House of Delegates were held in executive session to permit free discussion of the many wartime problems coming before the representatives of the medical profession. Departing from a custom of some years' standing, the annual meeting was held on the first three days of the week, with the House of Delegates convening Sunday evening. The first session was devoted to hearing reports of incoming and outgoing officers and elaboration of printed committee reports earlier submitted. Adjourning the first session at 9:30 p. m., the House of Delegates did not convene again until Monday evening so as to permit the reference committees, appointed by Speaker R. M. Kurten, Racine, to meet during the following day. The reference committees were composed of the following:

Committee on Credentials

Dr. C. A. Armstrong, Prairie du Chien, chairman

Dr. O. A. Stiennon, Green Bay

Dr. W. M. Trowbridge, Viroqua

Committee on Reports of Officers and Standing Committees

Dr. Irwin Schulz, Milwaukee, chairman

Dr. A. M. Christofferson, Waupaca

Dr. T. C. Hemmingsen, Racine

Dr. J. K. Trumbo, Wausau

Committee on Resolutions and Amendments to the Constitution and By-laws

Dr. K. H. Doege, Marshfield, chairman

Dr. J. S. Supernaw, Madison

Dr. L. O. Simenstad, Osceola

Dr. Charles Fidler, Milwaukee

Dr. H. M. Caldwell, Columbus

RESOLUTION ON BUTTER ADOPTED

The following resolution was presented to the House of Delegates by Dr. C. A. Dawson of River Falls and adopted by the House on September 15:

WHEREAS, During recent years there has arisen in the field of nutrition a group which has furthered the interest of butter substitutes, and

WHEREAS, In the opinion of competent scientists in the field of nutrition there is a natural growth factor in unadultered dairy butter which butter substitutes do not possess

Therefore, be it resolved, That the House of Delegates of the State Medical Society of Wisconsin go on record by giving its approval to natural dairy butter in preference to any artificial substitute.

At the Tuesday evening session, the recommendations of the Reference Committee on Reports of Officers and Standing Committees were received and adopted without change. A portion of the report of the Committee on Resolutions and Amendments to the Constitution and By-laws also was received, and the meeting was adjourned at 8:15 p. m. to permit the delegates to attend the smoker, scheduled at 8:30.

The House reconvened Tuesday morning and disposed of the business held over from the calendar of the evening before, at which time it adjourned and immediately reconvened as the third session to elect officers and dispose of its final business.

In the Auditorium

The scientific, technical, hobby and war exhibits proved to be of outstanding interest in the main arena of the Auditorium. In the hobby exhibits, visitors were amazed at the variety of interests followed by physicians in their more leisurely moments, while the stage of the arena, with its exhibits of wartime activities of the medical profession including the Procurement and Assignment Service, Emergency Medical Service under Civilian Defense, the recruiting boards, Red Cross and others, attracted a large number of visitors.

The scientific and technical exhibits, together with the hobby and war exhibits, served to fill completely the available space in the main arena of the Auditorium. Unlike former years, registration was somewhat more constant, as was also attendance, with the result that there was not the second day crowding formerly experienced, thus giving visitors an opportunity to view the various exhibits as long as they wished.

Marquette Students Guests

Students of the Marquette University School of Medicine were special guests of the Society throughout the meeting. According to Dean Eben J. Carey, the regents reviewed the annual meeting program and determined to adjourn all medical school classes in order that students might visit the various exhibits and listen to the outstanding speakers, an opportunity which they felt should not be overlooked.

The Annual Dinner

Anticipating that not more than 250 would attend the annual meeting dinner, as about 246 tickets had been sold prior to the dinner hour, a last minute sale of tickets raised the number to 385.

The program consisted of the raising of the colors by the color guard, and after dinner, presentation of distinguished guests by President Gundersen, a vigorous and well prepared address by Colonel F. W. Rankin, president of the American Medical Association and, finally, the installation of Dr. F. E. Butler, of Menomonie, as president with presentation of a gavel to the retiring president, Dr. Gunnar Gundersen, of La Crosse.

After the meeting adjourned, guests at the annual dinner attended a reception held by Past-president Gundersen, President Butler and President-elect Kurten in honor of Dr. Rankin.

Day-by-Day Registrants

Monday, September 14

Aageson, H. A. ----------Oconto
Abelmann, T. C. H. ----Watertown
Ackerman, E. T. -------Gays Mills
Adamkiewicz, J. J. ----Milwaukee
Allen, Jessie ----------Beloit
Andrew, C. H. ----------Platteville
Ansfield, M. J. ---------Milwaukee
Armstrong, C. A. -Prairie du Chien
Armstrong, J. H. ---New Richmond
Arveson, R. G. ----------Frederic

Bachman, Charles -----Milwaukee
Bachman, C. H. --------Milwaukee
Baker, R. G. ----------Tomahawk
Balkwill, C. A. ----------Grafton
Bargholtz, W. E. -------Reeseville
Barnes, H. T. ----------Delafield
Barnes, J. S. ----------Milwaukee
Barrock, J. J. ----------Milwaukee
Barta, E. F. ----------Wauwatosa
Bauer, K. T. ----------West Bend
Baum, E. L. ----------Milwaukee
Baumann, A. J. --------Milwaukee
Bayley, W. E. ----------La Crosse
Beck, R. W. ----------Milwaukee
Beckman, Harry -------Milwaukee
Behnke, E. J. ----------Milwaukee
Benton, R. W. ---------Milwaukee
Bentzien, E. W. --------Milwaukee
Bercey, J. E. ----------Milwaukee
Berg, W. R. ----------Gillett
Bernhart, E. L. --------Milwaukee
Bertram, B. J. ----------Algoma
Beutler, Alfred --------Milwaukee
Beebe, S. D. ----------Sparta
Bickler, E. P. ----------Milwaukee
Biller, S. E. ----------Milwaukee
Blom, Julius ----------Woodville
Blount, W. P. ----------Milwaukee
Blumenthal, R. W. -----Milwaukee
Boner, A. J. ----------Madison
Bongiorno, F. J. ----------Albany
Borman, M. C. ---------Milwaukee
Borsack, K. K. ------Fond du Lac
Bowen, H. P. ----------Watertown
Bowman, F. F. ----------Madison
Boyd, G. L. ----------Kaukauna
Brey, P. F. ----------Milwaukee
Brillman, C. R. ----------Cobb
Brook, J. J. ----------Milwaukee
Brooks, E. H. ----------Appleton
Brumbaugh, E. V. ------West Allis
Brunkhorst, R. O. -----Milwaukee
Buckley, R. A. ---------Eau Claire
Budny, C. L. ----------Milwaukee
Bump, W. S. ----------Rhinelander
Burgardt, G. F. --------Milwaukee
Burkhardt, E. W.
----------Menomonee Falls
Busse, A. A. ----------Jefferson
Butler, F. E. ----------Menomonie

Cahana, Stephen -------Milwaukee
Caldwell, H. M. --------Columbus
Cameron, E. S. ----------Madison
Cantwell, A. A. ---------Shawano
Carey, E. J. ----------Milwaukee
Carlson, G. W. ----------Appleton
Carroll, G. E. ----------Laona
Carson, W. J. ----------Milwaukee
Carter, H. M. ----------Madison
Cary, E. C. ----------Reedsville

Ceci, G. E. ----------Milwaukee
Champney, R. D. -------Milwaukee
Christiansen, J. --------Waukesha
Christofferson, A. M. ----Waupaca
Christofferson, H. H. --------Colby
Clark, O. C. ----------Oconomowoc
Clark, W. T. ----------Janesville
Cline, F. A. ----------Rhinelander
Cole, D. F. ----------Ripon
Cole, L. R. ----------Madison
Conroy, C. F. ----------Milwaukee
Cook, H. E. ----------Milwaukee
Cooksey, R. T. ----------Madison
Coon, H. M. ----------Madison
Cooper, G. A. ----------Madison
Copps, L. A. ----------Marshfield
Couch, T. T. ----------West Allis
Curran, W. P. ----------Antigo
Currer, P. M. ----------Milwaukee
Curreri, A. R. ----------Madison
Curtin, J. G. ----------Milwaukee

Dallwig, E. L. --------Wauwatosa
Daly, F. P. -------Chippewa Falls
Davee, Chalmer -------River Falls
Davies, R. E. ----------Waukesha
Davis, R. R. ----------Milton
Dawson, C. A. --------River Falls
Dehne, W. O. ----------Appleton
Demeter, N. D. --------Milwaukee
Dennis, J. F. ----------Waterloo
DeWitt, C. A. ---------Silver Lake
Dierker, O. F. ---------Watertown
Dieterle, J. O. ---------Milwaukee
Dodd, J. W. ----------Ashland
Doege, K. H. ----------Marshfield
Doege, P. F. ----------Marshfield
Douglas, F. A. ----------La Crosse
Dundon, J. R. ---------Milwaukee
Durner, U. J. ----------Milwaukee
Dvorak, H. J. ----------Milwaukee

Eagan, R. L. ----------La Crosse
Eberbach, C. W. -------Milwaukee
Echols, C. M. ----------Milwaukee
Eck, G. E. ----------Lake Mills
Egan, W. J. ----------Milwaukee
Egloff, L. W. ----------Pewaukee
Ekblad, V. E. ----------Superior
Eisele, P. L. ----------Milwaukee
Enzer, Norbert --------Milwaukee
Epley, O. H. -------New Richmond
Epstein, S. E. ----------Marshfield
Evans, E. P. ----------Milwaukee
Everts, E. L. ----------Milwaukee

Fabric, B. L. ----------Milwaukee
Falk, V. S. ----------Milwaukee
Farrell, H. J. ----------Milwaukee
Fazen, L. E. ----------Racine
Fazen, L. E., Jr. ----------Racine
Federman, E. H. --------Randolph
Feldt, R. H. ----------Milwaukee
Fellman, G. H. ----------Milwaukee
Fernan-Nunez, M. -----Milwaukee
Fidler, Charles --------Milwaukee
Filek, A. A. ----------Green Bay
Fitzgerald, G. F. ------Milwaukee
Fitzgerald, R. E. ------Milwaukee
Flarity, T. H. ----------Beloit
Foerster, H. R. --------Milwaukee
Fons, J. W. ----------Milwaukee
Ford, W. B. ----------Milwaukee

Fortier, C. A. H. -------Milwaukee
Fox, M. S. ----------Milwaukee
Francois, S. J. A. -----New Glarus
Franklin, Emil --------Milwaukee
Franklin, I. ----------Milwaukee
Frawley, D. D. --------Milwaukee
Frawley, W. J. ----------Appleton
Freeman, J. M. ----------Wausau
Frisch, R. A. ----------Milwaukee
Friske, O. W. ----------Beloit

Galasinski, R. E. ------Milwaukee
Gale, J. W. ----------Madison
Garding, C. J. ----------Jefferson
Garens, R. W. ---------Milwaukee
Garland, J. G. ---------Milwaukee
Gates, J. F. ----------Wauwatosa
Gavin, S. E. ----------Fond du Lac
Gilbertsen, C. R. --------Janesville
Glenn, E. C. ----------Pittsville
Glisch, W. P. ----------Milwaukee
Goodman, J. N. --------Milwaukee
Grab, J. A. ----------Madison
Gramling, H. J. --------Milwaukee
Gramling, J. J., Jr. ----Milwaukee
Greene, H. L. ----------Madison
Griffith, J. C. ----------Milwaukee
Grigsby, R. O. ----------Ashland
Grotjan, W. F. --------Milwaukee
Grover, F. L. ----------Hartland
Gruenwald, Ludwig ----Sheboygan
Gudex, V. A. ---------Fond du Lac
Guenther, O. F. ----Campbellsport
Guerin, L. H. ----------Milwaukee
Gundersen, Gunnar -----La Crosse
Gute, E. B. ----------Milwaukee

Habbe, J. E. ----------Milwaukee
Haberland, J. E. -------Milwaukee
Hafmeister, E. F. -------Waupaca
Hake, C. B. ----------Milwaukee
Hankwitz, A. W. ------Milwaukee
Hansen, J. W. ----------Milwaukee
Hansher, Ervin --------Milwaukee
Harder, H. ----------Milwaukee
Hardy, C. F. ----------Milwaukee
Hargarten, L. J. -------Milwaukee
Harper, C. A. ----------Madison
Harper, C. S. ----------Madison
Harris, A. J. ----------Adams
Hatfield, M. E. ---------Janesville
Hayman, C. S. ----------Boscobel
Hebenstreit, A. J. --------Waupun
Heeb, H. J. ----------Milwaukee
Hegner, G. T. ----------Appleton
Heidner, A. H. --------West Bend
Heidner, F. C. ----------Milwaukee
Heifetz, E. C. ----------Milwaukee
Heipp, E. A. ----------Milwaukee
Hemmingsen, T. C. --------Racine
Henney, C. W. ----------Portage
Heraty, J. A. ----------Milwaukee
Herner, W. L. ----------Milwaukee
Hershberg, R. A. ------Wauwatosa
Hertel, A. J. ----------Milwaukee
Herzog, J. V. ----------Milwaukee
Higgins, S. G. ---------Milwaukee
Hildebrand, G. J. ------Sheboygan
Hilger, W. A. ----------Milwaukee
Hiller, S. J. ----------Milwaukee
Hipke, L. W. ----------Milwaukee
Hirsh, Leon H. --------West Allis
Hitz, H. B. ----------Milwaukee

Hoffmann, G. H. _____West Allis
Hoffmann, J. G. _____Hartford
Hofmeister, F. J. _____Milwaukee
Holbrook, A. A. _____Milwaukee
Holbrook, A. T. _____Milwaukee
Horwitz, J. J. _____Milwaukee
Hough, A. G. _____Beaver Dam
Howard, M. Q. _____Wauwatosa
Howard, T. J. _____Milwaukee
Hughes, C. W. _____Wood
Hurth, O. J. _____Cedarburg
Hutter, A. M. _____Fond du Lac
Hypes, F. E. _____Three Lakes
Hyslop, V. B. _____Madison

Irwin, G. H. _____Lodi
Irwin, R. _____Milwaukee

Jackson, A. S. _____Madison
Jackson, E. _____Milwaukee
Jacobson, E. B. _____Milwaukee
Jaeschke, W. H. _____Fond du Lac
Janney, F. R. _____Wauwatosa
Jegi, H. A. _____Galesville
Jekel, J. M. _____Milwaukee
Johnson, B. F. _____Mondovi
Johnson, Frances _____Milwaukee
Jones, Beatrice O. _____Racine
Jones, G. S. _____Genesee Depot
Jorris, E. H. _____Madison
Juster, E. M. _____Madison

Kahn, Joseph _____Milwaukee
Karr, J. K. _____Milwaukee
Kastner, A. L. _____Milwaukee
Kauth, C. P. ____Port Washington
Kasak, Michael _____Wauwatosa
Kassowitz, K. E. _____Wauwatosa
Kasten, H. E. _____Beloit
Kay, E. M. _____Milwaukee
Kearns, W. M. _____Milwaukee
Kelly, G. F. _____Milwaukee
Kettelhut, E. J. _____Milwaukee
Kidder, E. E. _____Stevens Point
Kilian, A. D. _____Milwaukee
Killins, W. A. _____Green Bay
King, J. J. _____Milwaukee
King, J. M. _____Milwaukee
Klein, J. T. _____Milwaukee
Kleis, W. J. _____Milwaukee
Klumb, M. G. _____Milwaukee
Knauf, N. J. _____Chilton
Knudson, A. H. _____Milwaukee
Koch, V. W. _____Janesville
Koehler, A. G. _____Oshkosh
Koehler, J. P. _____Milwaukee
Kovacs, Arthur _____Milwaukee
Kradwell, W. T. _____Wauwatosa
Krahn, G. W. _____Oconto Falls
Kremser, V. C. _____Amery
Kretchmar, L. H. _____Milwaukee
Kretchmar, Morris ____Milwaukee
Kristjanson, H. T. _____Milwaukee
Kritter, F. J. _____Milwaukee
Kriz, G. A. _____Milwaukee
Krohn, Robert __Black River Falls
Krumbiegel, E. R. _____Milwaukee
Kuhn, H. J. _____Milwaukee
Kurten, R. M. _____Racine
Kurtz, E. C. _____Milwaukee
Kurtz, C. M. _____Madison
Kustermann, A. F. _____Milwaukee

Lademan, O. E. _____Milwaukee
Ladewig, A. W. _____Milwaukee
Ladewig, Harry _____Milwaukee
Lambert, J. W. _____Antigo
Lando, D. H. _____Waukesha

Lang, V. F. _____Milwaukee
Langenfeld, P. F. _____Theresa
Layton, O. M. _____Fond du Lac
Leahy, J. D. _____Park Falls
Leasum, R. N. _____Osseo
Lee, P. A. _____Milwaukee
Leitzell, P. W. _____Benton
Lettenberger, J. _____Milwaukee
Lewis, Marian _____Milwaukee
Lieberman, Benjamin __Milwaukee
Lifschutz, L. M. _____Racine
Lockhart, C. W. _____Mellen
Lotz, Oscar _____Milwaukee
Loughlin, T. F. _____Hartford
Ludden, J. B. _____Milwaukee
Lund, S. O. _____Cumberland

MacGregor, J. W. _____Portage
MacInnis, F. E. _____Milwaukee
MacKedon, W. L. _____Milwaukee
MacLaren, J. B. _____Appleton
MacRae, M. F. _____Milwaukee
Madison, F. W. _____Milwaukee
Malloy, T. E. _____Random Lake
Malnekoff, B. J. _____Milwaukee
Mannis, Harry _____Sparta
Marek, F. B. _____Racine
Margoles, F. C. _____Milwaukee
Markson, S. M. _____Milwaukee
Marquardt, C. R. _____Milwaukee
Marsh, H. C. _____Crandon
Marsh, H. E. _____Madison
Marshall, S. B. _____Hollandale
Martens, E. W. _____Milwaukee
Martin, H. G. _____Milwaukee
Mason, E. W. _____Milwaukee
McCann, Edith _____Milwaukee
McCarey, A. J. _____Green Bay
McDonald, C. F. _____Milwaukee
McDonald, R. E. _____Milwaukee
McDonough, K. B. _____Madison
McGinn, E. J. _____Marshfield
McIntosh, R. L. _____Madison
McMahon, F. B. _____Milwaukee
McNary, J. F. _____Milwaukee
Meany, S. G. _____East Troy
Meek, W. J., Ph. D. _____Madison
Megna, Salvatore _____Milwaukee
Melamed, Abraham ____Milwaukee
Mellencamp, F. J. _____Milwaukee
Merten, A. N. E. _____Milwaukee
Meyer, M. W. _____Ashland
Meyer, O. O. _____Madison
Midelfart, Peter _____Eau Claire
Miller, H. C. _____Racine
Miller, H. L. _____Milwaukee
Milson, Louis _____Green Bay
Minahan, J. J. _____Chilton
Minahan, P. R. _____Green Bay
Monsted, J. W. _____New London
Morgan, S. F. _____Milwaukee
Morrison, R. C. _____Winnebago
Morton, S. A. _____Milwaukee
Mueller, J. F. _____Plymouth
Munn, W. A. _____Janesville
Murphy, F. D. _____Milwaukee
Murphy, J. A. _____Milwaukee
Murphy, W. J. _____Milwaukee

Nadeau, A. T. _____Marinette
Nause, F. A. _____Sheboygan
Neidhold, Carl _____Appleton
Nesbit, W. M. _____Madison
Neupert, C. N. _____Madison
Nichols, C. H. _____Milwaukee
Niland, P. J. _____Milwaukee
Nimz, R. A. _____West Allis
Northey, T. M. _____Milwaukee

Oberbreckling, P. E. ___Milwaukee
Oberfeld, H. H. _____Milwaukee
O'Connor, W. F. _____Ladysmith
O'Donovan, T. W. _____Milwaukee
O'Leary, T. J. _____Superior
Olsen, Maurice _____Milwaukee
Olson, H. J. _____Milwaukee
O'Neal, Orvil _____Ripon
Orchard, H. J. _____Superior

Panetti, H. E. _____Milwaukee
Patek, A. J. _____Milwaukee
Pechous, C. E. _____Kenosha
Pegram, J. W. _____Milwaukee
Pember, A. H. _____Janesville
Perlson, P. H. _____Milwaukee
Peterman, M. G. _____Milwaukee
Pfefferkorn, E. B. _____Oshkosh
Pink, J. J. _____Milwaukee
Pippin, B. I. _____Richland Center
Pirsch, M. V. _____Kenosha
Pleyte, A. A. _____Milwaukee
Pomainville, F. X. ____Wis. Rapids
Pomainville, G. J. _____Nekoosa
Pomainville, L. C. ____Wis. Rapids
Pope, F. W. _____Racine
Popp, Albert _____Milwaukee
Prentice, J. W. _____Ashland
Pugh, G. J. _____Milwaukee
Purtell, R. F. _____Milwaukee

Quick, A. J. _____Milwaukee

Radloff, A. C. _____Plymouth
Ragan, W. F. _____Milwaukee
Rauch, W. A. _____Manitowoc
Reay, G. D. _____Onalaska
Rector, A. E. _____Appleton
Reifenrath, I. B. _____Milwaukee
Reuter, M. J. _____Milwaukee
Reuter, R. J. _____Madison
Richards, R. R. _____Durand
Ries, M. F. _____Brownsville
Rikkers, D. F. _____Milwaukee
Ringo, H. F. _____Milwaukee
Ritchie, Gorton _____Racine
Robinson, H. P. _____Milwaukee
Rodgers, R. S. ____Chippewa Falls
Rogers, E. H. _____Milwaukee
Rogers, M. F. _____Milwaukee
Rolfs, T. H. _____Milwaukee
Ross, M. E. _____Beloit
Russell, J. A. _____Random Lake
Russell, R. J. M. _____Milwaukee
Ryan, W. A. _____Milwaukee

Saketos, T. P. _____Milwaukee
Sander, O. A. _____Milwaukee
Sargeant, H. W. _____Wauwatosa
Sass, L. C. _____Milwaukee
Savage, G. T. _____Milwaukee
Sazama, F. B. _____Chippewa Falls
Schacht, E. W. _____Racine
Schacht, R. J. _____Racine
Schade, R. E. _____Milwaukee
Schaefer, A. A. _____Milwaukee
Schelble, E. J. _____Milwaukee
Schlaepfer, Karl _____Milwaukee
Schlomovitz, B. H. _____Milwaukee
Schlomovitz, E. H. _____Milwaukee
Schlossmann, B. _____Milwaukee
Schmidt, E. R. _____Madison
Schmidt, J. A. _____Milwaukee
Schmidt, R. H. _____Statesan
Schmit, Felix _____Milwaukee
Schneeberger, L. J. ____Milwaukee
Schneider, C. C. _____Milwaukee
Schneller, E. J. _____Racine

Schoenecker, E. A. ____Lake Mills
Scholter, E. A. W. ____Milwaukee
Schuler, F. X. _____Milwaukee
Schulte, G. C. _____Kenosha
Schulz, Irwin _____Milwaukee
Schumacher, H. S. ____Milwaukee
Schwartz, A. B. _____Milwaukee
Schweiger, L. R. _____Milwaukee
Seedorf, E. E. _____La Crosse
Seeger, S. J. ____Texarkana, Tex.
Seegers, F. W. _____Milwaukee
Senn, U. _____Milwaukee
Seymer, L. A. _____Wauwatosa
Shapiro, A. M. _____Milwaukee
Shaw, R. W. _____Marinette
Sherwood, M. W. _____Milwaukee
Siekert, H. P. _____Milwaukee
Silbar, S. J. _____Milwaukee
Simenstad, L. O. _____Osceola
Simonson, L. M. _____Sheboygan
Sincock, H. A. _____Superior
Sisk, Ira _____Madison
Smith, H. S. _____Cudahy
Smith, John W. _____Milwaukee
Smith, J. F. _____Wausau
Smith, S. M. B. _____Wausau
Smith, T. D. _____Neenah
Smith, Woodruff _____Ladysmith
Smuckler, R. H. _____Milwaukee
Snodgrass, T. J. _____Janesville
Soles, F. A. _____Platteville
Somers, A. J. _____Chippewa Falls
Sorenson, E. D. _____Elkhorn
Spiegelberg, E. H. _____Boscobel
Spilberg, S. _____Milwaukee
Spitz, M. M. _____Milwaukee
Sprague, L. V. _____Madison
Sproule, R. P. _____Milwaukee
Stadel, E. V. _____Reedsburg
Stahmer, A. H. _____Wausau
Stamm, L. P. _____Milwaukee
Stebbins, G. G. _____Madison
Steele, J. D., Jr. _____Milwaukee
Stemper, I. T. _____Oconomowoc
Stiennon, O. A. _____Green Bay
Stollenwerk, R. J. __Stevens Point
Stone, Mildred M. _____Berlin
Stovall, W. D. _____Madison
Stratton, F. A. _____Milwaukee
Strauch, C. B. _____Hazel Green
Supernaw, J. S. _____Madison
Sure, J. H. _____Milwaukee

Tabachnick, Harry ____Milwaukee
Tashkin, E. H. _____Milwaukee
Taylor, A. C. _____Appleton
Taylor, J. Gurney ____Milwaukee
Tessier, A. F. _____Milwaukee
Thill, G. E. _____Milwaukee
Thompson, I. F. _____Racine
Thorstensen, A. H. ____Milwaukee
Tormey, A. R. _____Madison
Trautmann, Milton _____Madison
Trowbridge, W. M. _____Viroqua
Truitt, J. W. _____Milwaukee
Tufts, Millard _____Milwaukee
Twohig, D. J. _____Fond du Lac

Unger, A. A. _____Milwaukee
Urdan, B. E. _____Milwaukee

Van Hecke, L. J. _____Milwaukee
Van Schaick, R. E. _____Marion
Vingom, C. O. _____Madison
Vogel, C. A. _____Elroy
von Jarchow, B. L. _____Racine

Wagner, P. C. _____Milwaukee
Wagner, W. A. _____Oshkosh
Waldman, I. J. _____Milwaukee
Walter, G. W. _____Racine
Warschauer, B. _____Milwaukee
Washburn, R. G. _____Milwaukee
Weber, A. J. _____Milwaukee
Weber, C. J. _____Sheboygan
Weeks, F. D. _____Ashland
Weingart, W. F. _____Milwaukee
Weisfeld, S. G. _____Milwaukee
Weisfeldt, L. A. _____Milwaukee
Weisfeldt, S. C. _____Milwaukee
Welke, E. G. _____Madison
Wenstrand, D. E. W. ___Milwaukee
Weston, F. L. _____Madison
Wheelihan, R. Y. _____Elm Grove
Wilets, J. C. _____Milwaukee
Wilker, W. F. _____Iola
Wilkinson, D. C. ____Oconomowoc
Williams, S. E. ___Chippewa Falls
Wilske, C. A. _____Milwaukee
Wilson, R. F. _____Beloit
Winter, A. E. _____Tomah
Wirka, H. W. _____Madison
Witcpalek, E. W. _____Kewaunee
Witcpalek, W. W. _____Algoma
Wochos, W. M. _____Kewaunee
Wollersheim, P. J. _Forest Junction
Wolter, S. H. _____Milwaukee
Wright, H. H. _____Milwaukee
Wright, R. S. _____Racine

Yaffee, Aaron _____Milwaukee

Zboralske, F. F. _____Fall Creek
Zellmer, C. E. _____Antigo
Zuercher, J. C. _____Milwaukee

Tuesday, September 15

Adams, R. W. _____Chetek
Adamski, A. W. _____Racine
Alcorn, M. W. _____Burlington
Allebach, H. K. _____Milwaukee
Altenhofen, A. R. ____Wauwatosa
Alvarez, R. L. _____Galesville
Anderson, H. A. ____Stevens Point
Andrews, M. P. _____Manitowoc
Ansfield, D. J. _____Milwaukee
Augur, A. _____Milwaukee
Aylward, T. J. _____Milwaukee

Bachhuber, A. M. _____Kaukauna
Bachhuber, F. G. _____Mayville
Backus, E. A. _____Milwaukee
Baker, V. L. _____Milwaukee
Bane, H. W. _____Madison
Bardenwerper, H. E. ___Milwaukee
Barr, A. H. _____Port Washington
Baumle, C. E. _____Monroe
Beck, A. A. _____Wautoma
Becker, W. C. _____Watertown
Bellehumeur, C. E. ____Milwaukee
Benjamin, H. B. _____Wauwatosa
Benn, H. P. _____Stevens Point
Bennett, J. F. _____Burlington
Benson, G. H. ____Richland Center
Benton, J. L. _____Appleton
Bernhard, L. A. _____Milwaukee
Bernhardt, E. L. _____West Bend
Bertolaet, E. E. _____Palmyra
Beyer, Hart _____Pittsville
Blanchard, H. H. _____Milwaukee
Blanchard, P. B. _____Cedarburg
Blankstein, S. S. _____Milwaukee
Bloom, C. S. _____Horicon
Bornstein, Max _____Milwaukee
Bornstein, S. L. _____Milwaukee

Bowen, E. W. _____Watertown
Bowing, Irwin _____Kenosha
Brachman, Louis _____Milwaukee
Brady, C. J. _____Lake Geneva
Brewer, J. C. _____Jefferson
Brickbauer, A. J. _____Plymouth
Brizard, J. L. _____West Allis
Brown, G. V. I. _____Milwaukee
Bruins, Dirk _____Milwaukee
Brussock, W. A. _____Wauwatosa
Buckley, W. E. _____Racine

Callan, P. L. _____Milwaukee
Campbell, P. E. _____Waukesha
Campbell, W. B. _____Waukesha
Cannon, H. J. _____Milwaukee
Carney, C. M. _____Beloit
Cash, I. I. _____Milwaukee
Caswell, H. O. _____Ft. Atkinson
Chorlog, J. K. _____Madison
Christensen, F. C. _____Racine
Cleary, J. H. _____Kenosha
Colgan, J. J. _____Milwaukee
Collentine, G. E. _____Milwaukee
Comstock, E. _____Arcadia
Connell, F. G. _____Oshkosh
Constantine, C. E. _____Racine
Conway, J. P. _____Milwaukee
Cramp, A. L. _____Gilman
Cron, R. S. _____Milwaukee
Curtin, D. W. _____Little Chute

Dana, D. B. _____Kewaunee
Dana, R. L. _____Fond du Lac
Darling, F. E., Jr. ____Milwaukee
Davidoff, I. Z. _____Milwaukee
Davies, E. B. _____Waukesha
Davis, M. D. _____Milton
Decker, H. G. _____Milwaukee
DeFazio, S. F. _____Kenosha
Dessloch, E. M. __Prairie du Chien
Dettman, N. F. _____Wauwatosa
Deysach, L. J. _____Wauwatosa
Diamond, C. O. _____Milwaukee
Dockery, G. A. _____Franksville
Doerr, August _____Milwaukee
Domann, W. G. __Menomonee Falls
Drew, F. E. _____Milwaukee
Driessel, S. J. _____Barton
Drissen, W. H. __Port Washington
Dryer, R. B. _____Poynette
Duer, G. R. _____Marinette

Eichenberger, C. R. ____Milwaukee
Eisenberg, Ed _____Milwaukee
Eisenberg, L. A. _____Milwaukee
Elliott, E. S. _____Fox Lake
Engel, A. C. _____New Holstein
Epperson, P. S. _____Milwaukee
Erickson, T. C. _____Madison

Fifrick, L. L. _____Wauwatosa
Fillbach, H. E. _____Monroe
Flaherty, G. S. __South Milwaukee
Flatley, M. A. _____Antigo
Flemming, E. E. _____Wausau
Frechette, F. M. _____Janesville
Frederick, R. H. _____West Allis
Frenzel, W. C. _____Wausau
Friedbacher, Karl ____West Allis
Froelich, J. A. _____Milwaukee
Froggatt, W. E. L. ___Cross Plains

Gabor, M. E. _____Milwaukee
Gallagher, J. T. F. _____Madison
Ganser, W. J. _____Madison
Garry, M. W. _____Montreal
Garvey, J. L. _____Milwaukee
Gascoigne, C. C. _____Kohler
Gebert, W. H. _____Wauwatosa

Gebhard, U. E. _____Milwaukee
Gertenbach, E. O. _____Milwaukee
Gilmer, L. T. _____Milwaukee
Gingrass, R. P. _____Milwaukee
Glaubitz, B. J. _____Sheboygan
Goldberg, Nat _____Milwaukee
Gonce, J. E. _____Madison
Gorder, A. C. _____Milwaukee
Gramling, J. J. _____Milwaukee
Gray, R. J. _____Evansville
Greenberg, A. I. _____Milwaukee
Grill, John _____Milwaukee
Grimm, J. J. _____Milwaukee
Grob, A. R. F. _____Milwaukee
Grossmann, L. L. _____Milwaukee
Gruesen, F. A. _____Ft. Atkinson
Gundersen, T. E. _____La Crosse

Hall, R. M. _____Milwaukee
Hamilton, W. P. _____Dodgeville
Hansen, H. J. ____Sheboygan Falls
Hansmann, G. H. _____Milwaukee
Hartman, R. C. _____Janesville
Hassall, J. C. _____Oconomowoc
Haushalter, L. E. _____Milwaukee
Hefke, H. W. _____Milwaukee
Heinan, F. C. _____West Allis
Heller, T. A. _____Milwaukee
Heraty, J. E. _____La Crosse
Herzog, P. S. _____Kenosha
Hittner, V. J. _____Seymour
Hoel, K. P. _____Pewaukee
Hogan, J. H. _____Racine
Hougen, E. T. _____Sheboygan
Huber, H. H. _____Milwaukee
Huibregtse, W. G. _____Sheboygan
Hunter, A. L. _____Madison

Ingwell, C. L. _____Deerfield
Inman, R. F. _____Montello
Irwin, H. J. _____Baraboo

Jackson, R. H. _____Madison
Jeffers, Dean _____Lake Geneva
Jewell, E. L. _____Loganville
Jochimsen, M. A. _____Milwaukee
Johnson, A. W. _____Hales Corners
Johnson, J. H. _____Milwaukee
Johnson, J. M. _____Ripon
Jones, M. L. _____Wausau
Jorgenson, H. L. _____Marinette
Joyner, T. H. _____Oregon
Jurgens, G. H. _____Wauwatosa

Karsten, J. H. _____Horicon
Katz, H. M. _____Cedarburg
Kauth, P. M. _____West Bend
Keenan, L. J. _____Fond du Lac
Kennedy, W. R. _____Milwaukee
Kenney, H. J. _____Delavan
Kent, L. T. _____Kenosha
Kern, T. J. _____Richfield
Kerscher, E. I. _____Casco
Kilkenny, G. S. _____Milwaukee
Kindschi, L. G. _____Monroe
Klein, T. W. _____Janesville
Knauf, J. A. _____Stockbridge
Koch, H. C. _____Berlin
Kohn, S. E. _____Milwaukee
Krehl, W. H. _____Madison
Krueger, E. N. _____Appleton
Kreul, R. W. _____Racine
Kruszewski, J. L. _____Milwaukee
Krzysko, S. L. _____Milwaukee
Kuehl, F. O. _____Green Bay
Kuhn, M. J. _____Milwaukee
Kult, A. S. _____Milwaukee

La Breck, F. A. _____Eau Claire
Lando, D. H., Jr. _____Milwaukee

Levitas, I. E. _____Green Bay
Liefert, W. C. _____Milwaukee
Lindner, A. M. _____Racine
Lindsay, W. T. _____Madison
Lobedan, E. T. _____Milwaukee
Lokvam, L. H. _____Kenosha
Loughlin, D. M. _____Milwaukee
Love, G. R. _____Oconomowoc
Lynch, H. M. _____West Bend

Maas, W. C. _____Rio
Mackoy, F. W. _____Milwaukee
Malone, J. Y. _____Milwaukee
Maloof, G. J. _____Madison
Mann, R. W. _____Milwaukee
Martin, R. E. _____Two Rivers
Mason, E. L. _____Eau Claire
Mason, P. B. _____Sheboygan
Mastalir, L. O. _____Burlington
Masten, M. G. _____Madison
Mayfield, A. L. _____Kenosha
McCabe, J. M. _____Sun Prairie
McCabe, John _____Milwaukee
McCormick, S. A. _____Madison
McGary, Lester _____Madison
McKillip, W. J. _____Milwaukee
McKittrick, N. W. _____Milwaukee
McMahon, H. O. _____Milwaukee
McRoberts, J. W. _____Sheboygan
Mielke, E. F. _____Appleton
Miller, J. F. _____Mt. Calvary
Mitchell, E. J. _____Brodhead
Moglowsky, S. _____Milwaukee
Mollinger, S. M. _____Milwaukee
Montgomery, R. P. ____Milwaukee
Moon, J. F. _____Baraboo
Moore, L. A. _____Monroe
Morrison, M. T. _____South Wayne
Mullen, R. A. _____Burlington
Murphy, J. H. _____Clintonville
Murawsky, W. J. _____Burlington

Nammacher, T. H. ___Oconomowoc
Natenshon, A. L. _____Milwaukee
Naylen, F. J. _____Adell
Nelson, W. L. ___Wisconsin Rapids
Nereim, T. J. _____Madison
Neville, M. E. _____Milwaukee
Nowack, L. H. _____Watertown
Nystrum, L. E. _____Medford

O'Brien, P. T. _____Menasha
O'Hara, J. J. _____Milwaukee
Ohlsen, M. P. _____Monticello
Olsen, L. C. J. _____Delafield
Owen, J. D. _____Milwaukee
Ozonoff, J. B. _____Milwaukee

Pallasch, F. J. _____Milwaukee
Patterson, L. G. _____Waupaca
Park, C. F. _____Milwaukee
Pawlisch, O. V. _____Reedsburg
Pawsat, E. H. _____Fond du Lac
Pearson, C. R. _____Baraboo
Pessin, Joseph _____Madison
Peters, L. M. _____Milwaukee
Peterson, D. R. _____Independence
Peterson, M. G. _____Lake Mills
Peyton, L. T. _____Milwaukee
Pfeifer, E. C. _____Racine
Powers, H. W. _____Milwaukee
Puestow, K. L. _____Madison
Purtell, P. J. _____Milwaukee

Quackenbush, E. C. ____Iron Ridge
Quade, R. H. _____Neenah

Raymond, R. G. _____Brownsville
Reinke, C. C. _____Milwaukee
Remley, A. R. _____Waupun

Reslock, C. P. _____Waupun
Rhea, C. W. _____Wood
Rice, E. M. _____Milwaukee
Robbins, J. M. _____Milwaukee
Roby, H. S. _____Milwaukee
Rosekrans, S. D. _____Neillsville
Rowan, J. P. _____Milwaukee
Ruehlman, D. D. _____Monroe
Ruppenthal, A. J. _____Milwaukee
Ruschhaupt, L. F. _____Milwaukee

Sadoff, H. B. _____Milwaukee
Salan, Sam _____Waupaca
Salinko, S. S. _____Milwaukee
Sargeant, G. M. __Prairie du Chien
Sauthoff, A. _____Mendota
Schacht, W. J. _____Milwaukee
Schaefer, C. O. _____Racine
Scheid, M. M. _____Rosendale
Schiek, I. E. _____Rhinelander
Schloemer, A. J. _Menomonee Falls
Schmallenberg, H. C. _New London
Schneider, C. S. _____Milwaukee
Schneiders, E. F. _____Madison
Schoenbechler, L. J. _____Omro
Schoenbeck, R. F. _____Stoughton
Schoenkerman, B. B. ___Milwaukee
Scholz, G. M. F. _____Milwaukee
Schulz, G. J. _____Union Grove
Schutte, A. G. _____Milwaukee
Schweitzer, W. A. _____Milwaukee
Senn, C. U. _____Ripon
Sevringhaus, E. L. _____Madison
Shaiken, Joseph _____Milwaukee
Shapiro, H. H. _____Madison
Sharpe, H. R. _____Fond du Lac
Shearer, H. A. _____Beloit
Shimpa, J. F. _____Milwaukee
Slnaiko, E. S. _____Markesan
Slutzky, Nathan _____Milwaukee
Smiles, C. J. _____Ashland
Smith, E. V., Jr. _____Fond du Lac
Smith, L. M. _____Oshkosh
Smits, R. H. _____West Allis
Sorkin, S. S. _____Evansville
Sprague, J. T. _____Madison
Springberg, J. C. _____Beloit
Stang, H. M. _____Eau Claire
Stern, C. S. _____West Allis
Stewart, W. C. _____Kenosha
Stockinger, R. E. _____Milwaukee
Straus, G. D. _____Milwaukee
Strong, R. G _____Manitowoc
Szymarek, J. E. _____Milwaukee

Tanner, J. W. _____Eau Claire
Teitgen, T. A. _____Manitowoc
Tharinger, E. L. _____Milwaukee
Thompson, A. S. _____Mt. Horeb
Thranow, J. A. _____Milwaukee
Tibbitts, U. J. _____Waukesha
Tormey, T. W. _____Madison

Ulrich, C. F. _____Kenosha
Urben, W. J. _____Mendota

Van Valin, E. C. _____Sussex
Venning, J. R. _____Ft. Atkinson
Voellings, W. J. _____Mukwonago
Vogel, T. L. _____Milton Junction

Wagner, R. F. _____Oshkosh
Walte, W. S. _____Watertown
Walker, L. J. _____Milwaukee
Wall, C. E. _____Manitowoc
Walsh, J. D. _____Muscoda
Watson, E. L. _____Ripon
Weber, F. T. _____Arcadia
Wegmann, G. H. _____Milwaukee

Welsch, J. M. _____Beaver Dam
Wendt, F. A. _____Johnson Creek
Werra, M. J. _____Waukesha
Wheeler, R. M. _____Madison
Wick, Samuel _____Wauwatosa
Wiese, M. E. _____Milwaukee
Wild, J. P. _____Milwaukee
Wilkinson, J. D. _____Oconomowoc
Wilkinson, J. F. _____Oconomowoc
Willett, Thomas _____West Allis
Winn, H. N. _____Madison
Wirthwein, C. J. _____Milwaukee
Wisiol, Erich _____Stevens Point
Witte, D. H. _____Milwaukee
Wochos, F. J. _____Kewaunee
Wolf, F. H. _____La Crosse
Wright, Marvin _____Rhinelander

Yockey, J. C. _____Fond du Lac

Ziegler, L. H. _____Wauwatosa
Zivnuska, J. F. _____Milwaukee
Zmyslony, W. P. _____Milwaukee
Zurheide, H. O. _____Milwaukee

Wednesday, September 16

Aageson, C. W. _____Madison
Adrians, W. A. _____Hortonville
Allen, W. J. _____Beloit

Bach, E. C. _____Milwaukee
Bach, M. J. _____Milwaukee
Barnet, E. G. ___Wisconsin Rapids
Bartels, G. W. _____Janesville
Batty, A. J. _____Portage
Beatty, S. R. _____Oshkosh
Beebe, G. W. _____Eau Claire
Beeson, H. B. _____Racine
Belson, H. J. _____Manitowoc
Bennett, L. J. __Wisconsin Rapids
Binnewies, F. C. _____Janesville
Binnie, Helen _____Kenosha
Bolger, J. V. _____Milwaukee
Bolton, E. L. _____Appleton
Bourne, N. W. _____Milwaukee
Boyer, H. N. _____Racine
Broderick, C. F. _____Milwaukee
Browne, C. F. _____Racine
Bryan, A. W. _____Madison
Burbach, T. H. _____Milwaukee
Burpee, G. F. _____Edgerton
Busby, W. W. _____Milwaukee
Burns, R. E. _____Madison
Byrnes, M. B. _____Milwaukee

Caples, B. M. _____Waukesha
Carey, H. W. _____Lancaster
Carl, E. E. _____Milwaukee
Christensen, H. H. _____Wausau
Coffey, C. J. _____Milwaukee
Coffey, S. E. _____Milwaukee
Coluccy, M. J. J. _____Madison
Cook, E. F. _____Milwaukee
Cook, F. S. _____Eau Claire
Coon, W. W. _____Walworth
Cordes, V. J. _____Wauwatosa
Costello, W. H. _____Beaver Dam
Cottingham, M. D. _____Kohler
Creasy, L. E. _____Monroe
Creswell, C. M. _____Kenosha
Crigler, R. R. _____Milwaukee
Crosby, E. P. _____Stevens Point
Crowe, N. F. _____Delavan
Cupery, D. P. _____Markesan

Davies, G. _____Waukesha
Davin, C. C. _____Kenosha
Davis, F. A. _____Madison

Dimond, W. B. _____Madison
Docter, J. C. _____Racine
Donath, L. H. _____Milwaukee

Ebert, R. O. _____Oshkosh
Edmondson, C. C. _____Waukesha
Eisenberg, P. J. _____Milwaukee
Ellis, I. G. _____Madison
Enright, J. A. _____Milwaukee
Epstein, Ely _____Milwaukee
Erdmann, N. C. _____Manitowoc
Ewell, G. H. _____Madison

Feld, D. D. _____Wauwatosa
Fiedler, Otho _____Sheboygan
Fisher, L. M. _____Milwaukee
Folsom, W. H. _____Fond du Lac
Frederick, A. J. _____Columbus
Friend, L. J. _____Beloit
Fuller, M. H. _____Green Bay

Gallaher, D. M. _____Appleton
Gnagi, W. B., Jr. _____Monroe
Goggins, J. W. _____Chilton
Greenthal, R. M. _____Milwaukee
Grove, W. E. _____Milwaukee
Grumke, E. H. _____Madison
Gunderson, R. H. _____Beloit

Haessler, F. H. _____Milwaukee
Hammond, R. W. _____Manitowoc
Helm, H. M. _____Beloit
Henken, J. F. _____Racine
Hoermann, B. A. _____Milwaukee
Hoffmann, L. A. ____Campbellsport
Housner, R. E. ___Richland Center
Hoyme, G. _____Eau Claire
Hughes, B. J. _____Winnebago
Hurlbut, J. A. _____Madison

Jamieson, R. D. _____Racine
Jefferson, R. A. _____Milwaukee
Jermain, W. M. _____Milwaukee
John, G. W. _____Beloit
Johnson, W. L. _____Janesville
Judge, T. A. _____Milwaukee

Kash, S. H. _____Cudahy
Keland, H. B. _____Racine
Kishpaugh, H. W. _____Beloit
Kleinboehl, J. W. _____Milwaukee
Kleinpell, W. C. _____Kenosha
Knutson, Oscar _____Osseo
Kriz-Hettwer, R. A. ___Milwaukee
Krueger, B. _____Cudahy
Kuegle, F. H. _____Janesville
Kwapy, C. R. _____Oconto

Langjahr, A. R. _____Milwaukee
Leonard, T. A. _____Madison
Littig, L. V. _____Madison
Lockhart, J. W. _____Oshkosh
Long, C. W. _____Milwaukee
Loughnan, A. J. _____Oconomowoc
Lowe, R. C. _____Neenah
Lungmus, B. A. _____Milwaukee

Mallow, H. G. E. _____Watertown
Margoles, Milton _____Milwaukee
Marshall, V. F. _____Appleton
Marshall, W. S. _____Appleton
May, J. V. _____Marinette
McCandless, E. E. ____Birnamwood
McCormick, G. L. _____Marshfield
McCormick, T. F. _____Milwaukee
McGarty, M. A. _____La Crosse
McGill, J. W. _____Superior
Miller, E. A. _____Watertown
Miller, E. W. _____Colgate
Miller, S. R. _____Stevens Point
Molsberry, J. M. _____Milwaukee

Nadeau, E. G. _____Green Bay
Neff, E. E. _____Madison
Nesbit, M. E. _____Madison
Neumann, W. H. _____Sheboygan
Newell, F. F. _____Burlington
Norviel, H. B. _____Phillips

O'Malley, W. P. _____Milwaukee
Osgood, C. W. _____Wauwatosa

Paul, L. W. _____Madison
Perkins, C. H. _____Kenosha
Peterson, E. F. _____Wauwatosa
Peterson, R. O. _____Racine
Pessin, S. B. _____Madison
Pifer, P. E. _____Kenosha
Pollack, S. K. _____Milwaukee
Pomainville, H. G. _____Nekoosa

Quick, E. W. _____Milwaukee
Quigley, L. D. _____Green Bay

Raube, H. A. _____Beloit
Rauch, A. M. _____Kenosha
Reznichek, C. G. _____Madison
Robb, J. J. _____Green Bay

Schenkenberg, G. E. _____Racine
Schiek, I. E., Jr. _____Rhinelander
Schmidt, A. C. _____Milwaukee
Schmidt, H. G. _____Milwaukee
Schmitt, A. J. _____Sheboygan
Schoofs, O. P. _____Milwaukee
Schowalter, R. P. _____Milwaukee
Schultz, I. _____Mazomanie
Schumm, H. C. _____Milwaukee
Schwittay, A. M. _____Madison
Sieker, A. W. _____Plymouth
Simon, L. J. _____Fond du Lac
Smith, L. D. _____Milwaukee
Sokow, Theodore _____Kenosha
Spelbring, P. G. _____Eau Claire
Sprague, J. P. _____Minocqua
Squier, T. L. _____Milwaukee
Squire, C. A. _____Sheboygan
Stannard, G. H. _____Sheboygan
Steckbauer, J. W. _____Manitowoc
Steen, M. H. _____Oshkosh
Stranberg, W. L. _____West Allis

Tenney, H. K. _____Madison
Terlinden, J. H. _____Bonduel
Tierney, E. F. _____Portage
Tolan, T. L. _____Milwaukee
Tomkiewicz, Nina _____Milwaukee
Towne, W. H. _____Hortonville
Treskow, F. G. _____Milwaukee
Troup, W. J. _____Green Bay
Trumbo, J. K. _____Wausau
Turner, V. C. _____Milwaukee

Walker, H. M. _____Dodgeville
Warner, R. C. _____Milwaukee
Wegmann, N. J. _____Milwaukee
Werner, D. J. _____Milwaukee
Wieder, L. M. _____Milwaukee
Wier, F. A. _____Racine
Wiesender, A. J. _____Berlin
Wilkinson, E. D. _____Milwaukee
Wilson, O. M. _____Wausau
Wirig, M. H. _____Madison
Woodhead, F. J. _____Waukesha

Young, A. F. _____Milwaukee
Younker, F. T. _____Galesville
Yost, R. G. _____Manitowoc

Zeiss, E. J. _____Appleton

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. E. S. Schmidt, Green Bay, President
Mrs. O. M. Layton, Fond du Lac, President-Elect
Mrs. R. B. Dryer, Poynette, Vice-President
Mrs. R. M. Kurten, Racine, Recording Secretary
Mrs. L. D. Quigley, Green Bay, Corresponding Secretary
Mrs. Charles Fidler, Milwaukee, Treasurer
Mrs. C. D. Partridge, Cudahy, Parliamentarian

COMMITTEE CHAIRMEN

Archives—
Mrs. J. P. Connell, Fond du Lac

Finance—
Mrs. J. R. Minahan, Wauwatosa

Hygeia—
Mrs. A. C. Taylor, Appleton

Organization—
Mrs. O. W. Friske, Beloit

Philanthropic—
Mrs. S. O. Lund, Cumberland

Press and Publicity—
Mrs. D. B. Dana, Kewaunee

Program—
Mrs. D. F. Gosin, Green Bay

Public Relations—
Mrs. R. D. Champney, Milwaukee

Legislation (special committee)—
Mrs. L. V. Sprague, Madison

Circulation of Bulletin (special committee)—
Mrs. W. A. Wagner, Oshkosh

Annual Meeting Auxiliary Registration Far Exceeds Expectations

Mrs. E. S. Schmidt Inducted as President, Mrs. Oliver M. Layton is Named President-Elect

WHEN the Committee on Registration and Credentials made its final report to presiding officers on the last day of the annual meeting, it was shown that registrants exceeded by eighty-seven those attending last year. Members were eager to learn of the wartime activities of various county auxiliaries and to exchange ideas and aims.

Thus, the annual convention of the Woman's Auxiliary to the State Medical Society of Wisconsin has been successfully concluded. The program was carried out as planned, and provided inspiration and entertainment for those in attendance. A most interesting and comprehensive picture of ingenuity and accomplishment was provided in the reports of the county auxiliary presidents. Members were fascinated by the ingenious methods employed by many auxiliaries to raise money for worthy purposes, and they learned that now, in every county, wartime activities are receiving more and more attention.

A great deal has been done during this last year under the very able leadership of Mrs. J. S. Supernaw, and the same sound planning will characterize the months ahead. Although it was learned with regret that the Portage and Green Lake–Waushara groups have decided to suspend activities for the duration, the remaining twenty-four organizations have coordinated Auxiliary aims with the demands of this emergency, and, thus, their members are found as leaders in the fields of home nursing, first aid, nurses' aides, nutrition and other phases of war work which are closely allied to the interests and training of the doctor's wife.

Two of Wisconsin's national officers, Mrs. R. E. Fitzgerald, national parliamentarian, and Mrs. E. J. Carey, national president-elect, were present at all sessions, although Mrs. G. H. Ewell, national press and publicity chairman, was unable to attend.

The Fourteenth Annual Meeting opened on Sunday, September 13, with preliminary registration during the afternoon and a dinner for the Board of Directors at the Hotel Schroeder in the evening. This directing board, consisting of state officers, the immediate past-president, chairmen of standing committees, and presidents of county auxiliaries, read and discussed reports of state officers and chairmen.

At the general business meeting on Monday morning convention guests were welcomed by Mrs. H. O. Zurheide, president of the Woman's Auxiliary to the Medical Society of Milwaukee County, and Mrs. E. D. Sorenson, who holds a similar position in the Walworth County Auxiliary, responded. A considerable portion of this session was

Mrs. O. M. Layton, Fond du Lac
President-Elect

given over to the county reports, which were unusually interesting and stimulating.

New business was introduced at the second session, held on Tuesday morning, September 15. The following constitutional amendment was presented and passed:

> "No member serving as officer, chairman of standing committee, or parliamentarian of the Woman's Auxiliary to the American Medical Association shall be eligible to serve as officer, chairman of standing or special committee or parliamentarian of the Woman's Auxiliary to the State Medical Society of Wisconsin."

It was explained by the president that this amendment had been approved at the preconvention board meeting because it would tend to dispel duplication, relieve the national officers from some of the heavy burdens imposed upon them, and would bring more members into active participation at the state level.

The voting body of the Auxiliary also revised Chapter 2, Section 4 of the By-laws by amending it to read:

> ". . . The total amount of the annual budget shall not exceed 90 per cent of the dues received during the preceding year. The remaining 10 per cent shall be placed in a reserve fund."

This section formerly provided that the total amount of the annual budget should not exceed 80 per cent of the dues, with the remaining 20 per cent being placed in the reserve fund. It was believed that such a change was warranted by the condition of the times, and that in this way it would be possible to carry out the proposed program for the coming year.

The matter of dues of those members whose husbands are now in service was discussed at length. It was suggested that doctors' wives who accompany their husbands be known as "service wives" and that county auxiliaries should have the privilege of meeting the dues of such members so that the paid membership of the county, state, and national groups should not be affected.

Mrs. E. S. Schmidt of Green Bay received the president's pin and was installed as president of the Auxiliary on Tuesday morning, following the election of officers which found Mrs. O. M. Layton of Fond du Lac chosen as president-elect; Mrs. R. B. Dryer of Poynette, vice-president; Mrs. R. M. Kurten, Racine, recording secretary; and Mrs. Charles Fidler, Milwaukee, as treasurer.

Following the second general business session, the post convention meeting of the Board of Directors, with Mrs. Schmidt presiding, was held. She announced her appointees for the next year as follows:

Corresponding Secretary:
Mrs. L. D. Quigley, Green Bay

Parliamentarian:
Mrs. C. D. Partridge, Cudahy

Committee Chairmen:
Archives—Mrs. J. P. Connell, Fond du Lac
Finance—Mrs. J. R. Minahan, Wauwatosa
Hygeia—Mrs. A. C. Taylor, Appleton
Organization—Mrs. O. W. Friske, Beloit
Philanthropic—Mrs. S. O.. Lund, Cumberland
Press and Publicity—Mrs. D. B. Dana, Kewaunee
Program—Mrs. D. F. Gosin, Green Bay

Public Relations—Mrs. R. D. Champney, Milwaukee
Circulation of Bulletin (special committee)—Mrs. W. A. Wagner, Oshkosh
Legislation (special committee)—Mrs. L. V. Sprague, Madison

Social Events

Socially, also, the Fourteenth Annual Meeting was considered a success. The usual meeting of old friends and new was heightened this year by a latent or active possibility, as the case might be, that this might be the last opportunity for some time to exchange greetings. A number of Auxiliary members, it was found, had already accompanied their husbands to new locations.

On Monday the members of the Walworth County Auxiliary were hostesses at a luncheon and bridge at the Hotel Schroeder. Music was supplied by two Milwaukee Auxiliary members, and guests enjoyed a style show by Hixon's Shop of Milwaukee. Particularly outstanding were the door prizes awarded during the afternoon. The main prize consisted of an immense V centerpiece made up entirely of defense stamps, while other prizes of defense stamp boutonnieres were also given.

The buffet supper, sponsored by the State Medical Society on Monday night, was gay and informal. Hostesses were members of the Milwaukee County Auxiliary. Seated at small tables, the guests enjoyed the delightful singing of the Schubert Ensemble. Following the supper, Mrs. Lucille La Chapelle of Lake Forest spoke on "An Excellent Thing in Woman." Her charming talk was illustrated with anecdotes and quips and was very well received.

Cudworth Post of the American Legion provided an entirely different atmosphere for the Auxiliary guests, and the Tuesday luncheon there was eminently successful. Problems and interests peculiar to the various committees and offices were discussed at luncheon round tables, under the leadership of state officers. Mrs. E. S. Schmidt presided at the luncheon and introduced guests and speakers. Members were greeted by Dr. Gunnar Gundersen, retiring president of the State Medical Society, and they then heard Miss Susan Burdick Davis speak on "Everyday Life in Wisconsin in 1848." An assistant dean of women at the University of Wisconsin for many years, Miss Davis was already known to many of her listeners as a charming and gracious lady and a sound historian. She took the guests back a century in state happenings and spoke with the ease of one who is extremely familiar with and interested in her subject. Members of the Kenosha County Auxiliary served as hostesses at this luncheon.

On Tuesday evening the members of the Woman's Auxiliary joined their husbands and friends for the annual dinner in the Crystal Ballroom of the Hotel Schroeder. They commented particularly on the lovely floral arrangements and, during the dinner, were proud to join in the birthday song to one of their members, Mrs. A. E. Rector. They watched the raising of the colors by a color guard from Camp Grant, Illinois, and later heard Colonel F. W. Rankin, president of the American Medical Association, speak on "The Doctor's Part in the War Program." Following the dinner, a reception given in honor of Colonel Rankin by President F. E. Butler, Past-president Gunnar Gundersen, and President-elect R. M. Kurten was well attended by physicians, Auxiliary members, and guests.

Address of 1942-1943 Auxiliary President

By MRS. E. S. SCHMIDT
Green Bay

IN ACCEPTING the office of president of the Woman's Auxiliary to the State Medical Society of Wisconsin, I am fully aware of the responsibilities entailed, the magnitude of my duties, and the response expected in return for the trust imposed in me.

I pledge you my best efforts and ask your cooperation. I am grateful for this opportunity to render service in the emergency now facing our beloved country.

With our nation at war our first duty is to unite with other state auxiliaries in an effort

Mrs. E. S. Schmidt, Green Bay
President

to meet the demands of civilian defense; to promote community health education; to organize classes in nutrition, first aid, and mental hygiene; to train nurses' aides, and to support all Red Cross activities.

May I direct the attention of our state members to two new sections which have appeared this year in *The Wisconsin Medical Journal.* One, a series of articles on nutrition, was published from January through May. The other, entitled "The Nation at War," presents pertinent information relative to the activities of the medical profession in serving its country during this time of war and will be continued for the duration.

This year, when our legislature is in session, I urgently advise each auxiliary president to appoint a legislative chairman who will plan a group study of medical legislation. Your state chairman will direct your efforts.

Interest members of your auxiliary in "Health Defense," the keynote of all programs for this year. Urge able women to direct groups interested in health education. Give comfort and help when needed to the wives of the doctors who are in service.

Build your study program on the "Credo of the Doctor's Wife in Wartime," written by Mrs. Hibbits for the August *Bulletin.* Members will be interested and united in effort—a worthwhile endeavor in these critical times.

Report of the 1941-1942 Auxiliary President*

By MRS. J. S. SUPERNAW
Madison

IT IS gratifying to have so many here this morning, and I am happy to greet you in the name of the Woman's Auxiliary to the State Medical Society of Wisconsin. We particularly welcome those of you who are new to this organization and our two national representatives who are with us this morning, Mrs. R. E. Fitzgerald, national parliamentarian, and Mrs. E. J. Carey our new national president-elect. Mrs. George Ewell, another Wisconsin woman who is on the national board as press and publicity chairman, was unable to be with us today. We are honored to have Wisconsin so well represented.

I wish to thank the Milwaukee County Auxiliary for their gracious hospitality to us, and the Kenosha and Walworth County Auxiliaries for their help, as co-hostesses, in making this the delightful convention it is. The mechanics of the convention have been well arranged, and the cordial and friendly manner in which we have been received and

* Presented at the Fourteenth Annual Meeting of the Woman's Auxiliary to the State Medical Society, Monday, September 14, 1942.

entertained makes us appreciative of all our hostesses have done to make this a pleasant occasion for us.

We, as a state organization, are aware of the splendid leadership we have enjoyed in our national officers and chairmen. They have been effective in office because they have given creative effort to their posts and have been women of integrity and purpose. Mrs. R. E. Mosiman, who was with us last year at the time of the annual meeting, was most helpful in her suggestions and guidance. Mrs. F. N. Haggard, our present national president, regrets that she is unable to be with us for this meeting because of conflicting and previously made arrangements to be with the Nebraska Auxiliary at this time. Mrs. Haggard sent her greetings to the Woman's Auxiliary of the State Medical Society of Wisconsin and her best wishes for a successful year.

Immediately after the annual meeting in 1941, upon assuming office, letters and material were sent to the chairmen appointed and the work of the year was planned. I am sincerely grateful for the response and effort made by the officers and chairmen who have served with me this year in behalf of the work of the Woman's Auxiliary. What accomplishments we have to our credit at this annual accounting is directly due to the loyal and thoughtful cooperation of these people.

I attended the mid-year national meeting last November in Chicago, and enjoyed meeting the national officers and hearing the reports of the work being done throughout the country. I have tried to pass on to you the suggestions that came out of that meeting and to follow the plans proposed then in the work of our state Auxiliary.

When we met a year ago, war was an eventuality. It became a reality before our year was very far along, and new duties and responsibilities were imposed upon us. Food, housing, transportation, and civilian health took on acute proportions in many of our communities. Committees were appointed in each county to work with the Emergency Medical Service chairman.

No new counties were organized this year in view of the fact that many of the newer organizations needed help in strengthening their programs and working units and that our whole membership was engaged in Red Cross training courses and workroom demands. I regret to announce that two county auxiliaries have withdrawn from active participation in Auxiliary affairs, and I sincerely hope that these groups, Portage and Green Lake–Waushara counties, may be reinstated after the pressure of the present emergency is past.

I have visited a number of the county groups during the last year and wish that it had been possible to accept all of the gracious invitations extended to me. It is at the county level that the work of our organization is done, and it is interesting and inspiring to meet the women throughout the state who are doing the work and to see their programs in action.

Our midyear meeting occurred on a wretched day in February but, being a stouthearted group, we had a good attendance in spite of the weather, and excellent reports were presented.

Mrs. G. E. Stoddart, state commander of the Women's Field Army for the Control of Cancer, has sent her greetings to us at this meeting and her grateful appreciation for the outstanding work done by the Woman's Auxiliary to the State Medical Society of Wisconsin this year in the program for cancer control.

A state legislative chairman was appointed for the first time this year, and many of the county programs have included a detailed study of government procedures. This being a legislative year, it is hoped that we may arrange to have you visit the legislature, when it is in session, to hear the discussions and decisions on health bills.

Auxiliary handbooks were purchased and distributed to the officers and state chairmen. Subscription to *The Bulletin* was encouraged for use of its excellent material prepared by our national officers and committee chairmen and for the closer coordination it gives our work.

The Woman's Auxiliary to the American Medical Association has established a central office in Chicago, with Miss Margaret Wolfe in charge, for handling of supplies and expediting the work of the Auxiliary.

As my term of office draws to a close, I am aware of the many things left undone. I am deeply appreciative of the loyal support you have given me at all times; my fumblings have often been glossed over by the energy and imagination with which you have come to my rescue. I regret that the close association which working together has engendered is at an end, but I hope that the personal ties thus built may endure.

Registrants at Auxiliary Meeting

Ashland–Bayfield–Iron
Grigsby, Mrs. R. O.
Prentice, Mrs. J. W.

Barron–Washburn–Sawyer–Burnett
Lund, Mrs. S. O.

Brown–Kewaunee–Door
Dana, Mrs. D. R.
Filek, Mrs. A. A.
Goggins, Mrs. George
McCarey, Mrs. A. J.
Schmidt, Mrs. E. S.
Wollersheim, Mrs. P. J.

Chippewa (no Auxiliary organized)
Rodgers, Mrs. R. S. (guest)

Columbia–Marquette–Adams
Caldwell, Mrs. H. M.
Dryer, Mrs. R. B.
MacGregor, Mrs. J. W.

Dane
Brindley, Mrs. B. I.
Coon, Mrs. H. M.
Curreri, Mrs. A. R.
Ganser, Mrs. W. J.
Green, Mrs. H. L.
Harper, Mrs. C. A.
Larson, Mrs. G. B. (guest)
McCormick, Mrs. S.
Neupert, Mrs. C. N.
Sprague, Mrs. J. T.
Sprague, Mrs. L. V.
Stebbins, Mrs. G. G.
Sullivan, Mrs. W. E.
Supernaw, Mrs. J. S.
Tormey, Mrs. T. W., Jr.
Winn, Mrs. H. N.

Dunn (no Auxiliary organized)
Butler, Mrs. F. E. (guest)

Fond du Lac
Connell, Mrs. J. P.
Gavin, Mrs. S. E.
Guenther, Mrs. O. F.
Hutter, Mrs. A. M.
Johnson, Mrs. J. M.
Keenan, Mrs. L. J.
Layton, Mrs. O. M.
McGauley, Mrs. F. M.
O'Neal, Mrs. Orvil (guest)
Pawsat, Mrs. E. H.
Raymond, Mrs. R. G.
Reslock, Mrs. C. P.
Twohig, Mrs. H. E.
Twohig, Mrs. J. E.
Sharpe, Mrs. H. R.
Smith, Mrs. E. V., Jr.

Grant (no Auxiliary organized)
Soles, Mrs. F. A. (guest)
Strauch, Mrs. C. B. (guest)

Kenosha
Andre, Mrs. E. F.
Graves, Mrs. J. P.
Herzog, Mrs. P. S.
Lokvam, Mrs. L. H.
Rauch, Mrs. A. M.
Ripley, Mrs. H. M.
Ruffolo, Mrs. A. F.
Schulte, Mrs. George
Stewart, Mrs. W. C.
Ulrich, Mrs. C. F.

La Crosse
Reay, Mrs. G. D.
Seedorf, Mrs. E. E.
Townsend, Mrs. H. E.
Wolf, Mrs. F. H.

LaFayette (no Auxiliary organized)
Calvert, Mrs. William (guest)

Manitowoc
Andrews, Mrs. M. P.
Cary, Mrs. E. C.
Huth, Mrs. E. W.
Martin, Mrs. R. E.

Marathon (no Auxiliary organized)
Frenzel, Mrs. W. C.
Kidder, Mrs. E. E.

Marinette–Florence
Duer, Mrs. G. R.
May, Mrs. J. V.

Milwaukee
Adamkiewicz, Mrs. J. J.
Allebach, Mrs. H. K.
Barta, Mrs. E. F.
Baumann, Mrs. A. J.
Bercey, Mrs. J. E.
Behnke, Mrs. E. J.
Bernhart, Mrs. E. L.
Bickler, Mrs. E. P.
Blumenthal, Mrs. R. W.
Borman, Mrs. M. C.
Bourne, Mrs. N. W.
Burgardt, Mrs. G. F.
Carey, Mrs. E. J.
Champney, Mrs. R. D.
Cook, Mrs. H. E.
Currer, Mrs. P. M.
Curtin, Mrs. J. G.
Dix, Mrs. C. R. (guest)
Dundon, Mrs. J. R.
Everts, Mrs. E. L.
Fidler, Mrs. Charles
Fitzgerald, Mrs. G. F.
Fitzgerald, Mrs. R. E.
Foley, Mrs. L. J.
Ford, Mrs. W. B.
Frawley, Mrs. D. D.
Fromm, Mrs. A. H.
Gaenslen, Mrs. F. J. G.
Gebhard, Mrs. U. E.
Gilchrist, Mrs. R. T.
Gramling, Mrs. H. J.
Gramling, Mrs. J. J., Jr.
Grotjan, Mrs. W. F.
Gumerman, Mrs. G. J.
Hansher, Mrs. Ervin
Heeb, Mrs. H. J.
Heidner, Mrs. F. C.
Hoffmann, Mrs. G. H.
Hopkinson, Mrs. Manette
Howard, Mrs. M. C.
Howard, Mrs. T. J.
Hughes, Mrs. C. W.
Jackson, Mrs. Edward
Janney, Mrs. F. R.
Jekel, Mrs. J. M.
Jermain, Mrs. W. M.
Joseph, Mrs. W. A.
Kelley, Mrs. J. O.
King, Mrs. J. J. (guest)
Kovacs, Mrs. A.
Kozina, Mrs. F. J.
Kruszewski, Mrs. J. L.
Langjahr, Mrs. A. R.
Lawler, Mrs. E. M.
Lee, Mrs. P. A.
Leeander, Mrs. G. A. (guest)
Lettenberger, Mrs. Joseph
Liefert, Mrs. W. C.
Mackoy, Mrs. F. W.
Malone, Mrs. J. Y.
Megna, Mrs. Salvatore
Melster, Mrs. W. H. (guest)
Minahan, Mrs. J. R.
Mollinger, Mrs. S. M.
Morgan, Mrs. J. E.
McCabe, Mrs. J. O.
McDonald, Mrs. C. F.
McGovern, Mrs. J.
McKillip, Mrs. W. J.
McMahon, Mrs. F. B.
Northey, Mrs. T. M.
Osgood, Mrs. C. W.
Owen, Mrs. J. D.
Partridge, Mrs. C. D.
Peterson, Mrs. E. F.
Pfeil, Mrs. R. C.
Powers, Mrs. H. W.
Pugh, Mrs. G. J.
Rettig, Mrs. Frank
Rettig, Mrs. H.
Rice, Mrs. E. M.
Rolfs, Mrs. T. H.
Schelble, Mrs. E. J.
Schelble, Mrs. John
Schlueter, Mrs. U. A.
Schowalter, Mrs. R. P.
Schubert, Mrs. F. J.
Schulz, Mrs. Irwin
Shapiro, Mrs. A. M.
Silbar, Mrs. S. J.
Smith, Mrs. H. S.
Spitz, Mrs. M. M.
Sproule, Mrs. R. P.
Stamm, Mrs. L. B.
Stockinger, Mrs. R. E.
Taylor, Mrs. J. G.
Thill, Mrs. G. E.
Tufts, Mrs. Millard
Walton, Mrs. W. B.
Warmolts, Mrs. I. J. (guest)
Washburn, Mrs. R. G.
Wenstrand, Mrs. D. E. W.
Witte, Mrs. D. H.
Zurheide, Mrs. H. O.
Ziegler, Mrs. L. H.

Oconto (no Auxiliary organized)
Aageson, Mrs. H. (guest)
Berg, Mrs. W. R. (guest)

Oneida (no Auxiliary organized)
Bump, Mrs. W. S. (guest)

Outagamie
Neidhold, Mrs. C. D.
Rector, Mrs. A. E.
Taylor, Mrs. A. G.

Polk
Arveson, Mrs. R. G.
Kremser, Mrs. V. C.

Racine
Adamski, Mrs. A. W.
Albino, Mrs. J. M.
Brehm, Mrs. H. G.
Browne, Mrs. C. F.
Dockery, Mrs. G. A.
Gillett, Mrs. G. N.
Kurten, Mrs. R. M.
Pope, Mrs. F. W.
Thompson, Mrs. I. F.

Richland (no Auxiliary organized)
Pippin, Mrs. B. I. (guest)

Rock
Carney, Mrs. C. M.
Clark, Mrs. W. T.
Friske, Mrs. O. W.
Gilbertsen, Mrs. C. R.
John, Mrs. G. W.
Kasten, Mrs. H. E.
Ross, Mrs. M. E.
Snodgrass, Mrs. T. J.
Wilson, Mrs. R. F.

Sheboygan
Hansen, Mrs. H. J.
Hildebrand, Mrs. G. J.
Hougen, Mrs. E. T.

Trempealeau–Jackson–Buffalo
Jegi, Mrs. H. A.

Walworth
Halsey, Mrs. R. C.
Jeffers, Mrs. D. H.
Keenan, Mrs. T. P.
Meany, Mrs. S. G.
O'Keefe, Mrs. F. L.
Rawlins, Mrs. J. A.
Sorenson, Mrs. E. D.

Washington–Ozaukee
Barr, Mrs. A. H.
Hurth, Mrs. O. J.
Lynch, Mrs. H. M.
Reichert, Mrs. J. E.

Waukesha
Aplin, Mrs. F. W.
Doege, Mrs. K. W.
Edmondson, Mrs. C. C.
Egloff, Mrs. L. W.
Hassall, Mrs. J. C.
Murphy, Mrs. W. T.
Oatway, Mrs. W. H.
Nammacher, Mrs. T. H.
Nixon, Mrs. H. G. V.
Peters, Mrs. H. A.
Voje, Miss H. C.

Waupaca–Shawano
Monsted, Mrs. J. W.
Patterson, Mrs. L. G.
Salan, Mrs. Sam

Winnebago
Koehler, Mrs. A. C.
Pfefferkorn, Mrs. E. B.
Smith, Mrs. T. D.
Wagner, Mrs. R. F.
Wagner, Mrs. W. J.

Wood
Glenn, Mrs. E. C.
Pomainville, Mrs. L. C.

Out-of-State
Conley, Mrs. J., Boston, Mass. (guest)
Knox, Mrs. L. M., Berkeley, Cal. (guest)

A History of the Woman's Auxiliary to the Medical Society of Milwaukee County, Oct., 1941 to May, 1942

Compiled by MRS. E. F. PETERSON

THE Woman's Auxiliary to the Medical Society of Milwaukee County began its activities for the year 1941 and 1942, with the following officers:

President—Mrs. R. D. Champney
President-elect—Mrs. H. O. Zurheide
Vice-president—Mrs. A. R. Langjahr
Recording Secretary—Mrs. L. B. Uszler
Corresponding Secretary—Mrs. P. A. Lee
Treasurer—Mrs. M. C. Borman
Parliamentarian—Mrs. W. M. Jermain
Directors—Mrs. C. D. Partridge, Mrs. W. B. Ford, Mrs. V. F. Lang, Mrs. W. C. Liefert, Mrs. E. F. Barta, Mrs. F. R. Janney, Mrs. W. A. Ryan

This year has been one of outstanding accomplishment by our working committees. The reports submitted by the chairmen of these committees are proof of the magnificent spirit and boundless energy of our members. You will note also that every report is permeated with the fervor of patriotism. This thought brings to mind the report of Mrs. J. L. Kinsey of the *Visiting Nurse Committee*. We all remember with pleasure a dramatic portrayal of the various types of work in which the committee is engaged. In this connection, Mrs. Kinsey wishes special credit accorded to Mrs. M. C. Borman who wrote and directed this delightful play. In addition, Mrs. Kinsey submits a lengthy list of practical infants' garments and hospital supplies completed.

The Civilian Defense Committee reports the organization of a motor corps consisting of twenty-six members of the Auxiliary operating under the direction of the Milwaukee County Civilian Defense Office. This service is supplemented by members who are graduate nurses, taking the instructors' course in home nursing. The Auxiliary has been represented at every meeting of the Advisory Board of the Milwaukee County Council of Defense by both our chairman and cochairman, Mrs. W. C. Liefert and Mrs. G. J. Pugh.

The Philanthropic Committee has devised a plan wherein all members who are graduate nurses may organize a so-called refresher course, for the purpose of preparing themselves to instruct lay groups in home nursing. Their plan, though still not completed in detail, has the approval of the Auxiliary Board and also the Medical Society of Milwaukee County. They will receive aid and guidance in this enterprise from the Red Cross.

Mrs. A. R. Langjahr, for the *Red Cross Committee*, reports eighty dozen surgical bandages and dressings have been completed, together with an additional thirty knitted garments. Mrs. P. A. Lee and Mrs. R. E. McDonald deserve special mention, having won the Small Red Cross for hours of service in our unit. On February 5, a card party was given at Tripoli Mosque under the able direction of Mrs. H. O. Zurheide, for the benefit of the Red Cross. This party netted the organization $247.50. Mrs. Zurheide also reports that the *Public Relations Committee* has furnished fifty-three speakers from the Medical Society to lay organizations.

Mrs. A. R. Langjahr, as chairman of the *Membership Committee*, reports eighteen new members, bringing our present membership to 415.

The *Educational Committee*, with Mrs. E. J. Behnke, as chairman, has been alert in the suppression of unethical medical advertising and quack remedies. The committee reports Milwaukee is largely free from these nuisances at the present time.

The *Flower and Courtesy Committee*, with Mrs. M. Q. Howard as chairman, reports that eleven

notes were written and flowers sent, both in sympathy and appreciation, suitable to the occasion.

Mrs. R. T. Gilchrist reports for *Hygeia* that the subscription list has been decreased because many doctors have been called into service and therefore have not renewed subscriptions. The committee is also curtailing *Hygeia* donations so that any surplus funds may be given to the Red Cross. However, at the last meeting of the Board, it was voted that sixty subscriptions would be donated.

The second year of the *Study Group*, under the leadership of Mrs. C. D. Partridge, proved most interesting. Books relating to the medical profession were reviewed by Mrs. Borman, Mrs. V. F. Lang, Mrs. Behnke, and Mrs. Partridge. Three meetings were devoted to entertaining the Medical Auxiliary Red Cross Production Unit during its working period.

And now, the *Program Committee*,—that really hard-working committee, which has provided us with a variety of outstanding programs throughout the year, under the capable leadership of Mrs. R. E. McDonald.

The opening meeting in October was a reception and tea at the City Club in honor of our new officers. The feature of the afternoon was a style show. Costumes from the Florence Danforth Shoppe were displayed by models chosen from our own membership. The piano accompaniment of Mrs. Arno Fischer was supplied by the *Music Committee*.

November 14 found us at the YWCA for luncheon. Our guest speaker, Dr. J. C. Sargent, gave a most inspiring talk. His subject, "This our Oath," was his own modern interpretation of the pledge of Hippocrates.

The December meeting, held at the Schroeder Hotel, will long be remembered because the entire program was furnishd by our own members, which lent a feeling of warmth and intimacy to a very special occasion—our tenth anniversary. Our speakers, Mrs. H. J. Gramling, to whom we owe our existence, and Mrs. J. C. Sargent, our first president, were delightfully reminiscent. They were especially enjoyed by those of us who were charter members and had the great privilege of working with them. This meeting was further enriched by our music chairman, Mrs. R. D. Bergen, who presented our own chorus in Christmas carols, directed by Mrs. L. M. Warfield and accompanied by Mrs. G. F. Kelly, pianist, and Mrs. E. M. Lawler and Mrs. G. E. Thill, violinists. It was at this program that Mrs. Borman's drama was presented on behalf of the Visiting Nurse Committee.

For our January meeting we went to the Pfister Hotel. Our speaker was Mr. Irving Schwerke, noted music critic, who entertained with anecdotes of his life in Paris over a period of twenty years.

The February luncheon was held at the Schroeder Hotel on Friday, the thirteenth. We were fortunate to secure Lieutenant Commander Marion B. Sulzberger, M. D., of the U. S. Navy, who introduced us to "Cosmetics I have Met." His experiences were illuminating and instructive. Dr. C. W. Eberbach, president of the Medical Society of Milwaukee County, was our very special guest, and invitations were extended to our adjoining county medical auxiliaries.

The March meeting was held at the Knickerbocker Hotel. Dr. R. E. Fitzgerald gave an informative talk on Procurement and Assignment. Our guest speaker was Dr. Tibor Payzs, internationally known as a student and teacher of political science.

The April meeting at the Pfister Hotel was our annual Mother and Daughter Day. We had with us on this occasion Mr. Edward Harris Huth, who brought with him quantities of various flowers and demonstrated highly artistic floral arrangements. The beauty of this program was enhanced by our Music Committee who enchanted us with excerpts from Sari, presented by members of the Milwaukee Light Opera Company under the direction of Mrs. L. M. Warfield.

To Mrs. E. F. Barta and the *Social Committee* we owe a debt of gratitude for providing an attractive background for our meetings. On their shoulders rests the burden of selecting our meeting places, taking reservations, selling luncheon tickets, decorating the tables and contributing their services in so many ways to the general success of the luncheons. Their crowning success was the dinner dance given at the University Club, May 2, which was much enjoyed and well attended.

The *Press and Publicity Committee*, under the leadership of Mrs. E. M. Lawler, has been very energetic in keeping our activities before the public, with a view to stimulating interest in the work of the Auxiliary and thereby increasing our attendance.

The *Telephone Committee* has had unusual demands upon its time this year due to the many calls necessary to the work of the Civilian Defense, Red Cross, and Social Committees. Our president reports splendid work done by this committee.

We have all followed the splendid monthly contributions to the *Milwaukee Medical Times* by our president, who has maintained an ideal of efficiency throughout her administration. From her articles in the *Times* you have learned each month of the tremendous amount of work undertaken and accomplished by her committees and herself and, also, that I have reported only a small fraction of the work actually accomplished. In this changing world of today, it is beyond the reach of our intelligence to predict the trend of our work for the coming year. However, I do know that the influence of this administration will carry through and give strength to the workers of the future.

Is your Auxiliary using *The Bulletin* for program material? Have your secretary subscribe to it for the use of your officers and chairmen.

THE ART OF DOING THINGS WELL

THE WELL-BEING of hundreds of thousands of diabetic patients would be disturbed if the strength of lots of Iletin (Insulin, Lilly) should vary from the potency stated on the label. Uniformity is assured by vigilant testing—tests of crude materials, tests to control processing, tests for purity, sterility, and stability. Data for the standardization of one master lot of Iletin (Insulin, Lilly) may aggregate convulsion tests on several thousand mice and blood-sugar curves of one or two thousand rabbits. It is estimated that more than a million blood-sugar determinations have been made in the twenty years of Insulin testing—another example of the art of doing things well.

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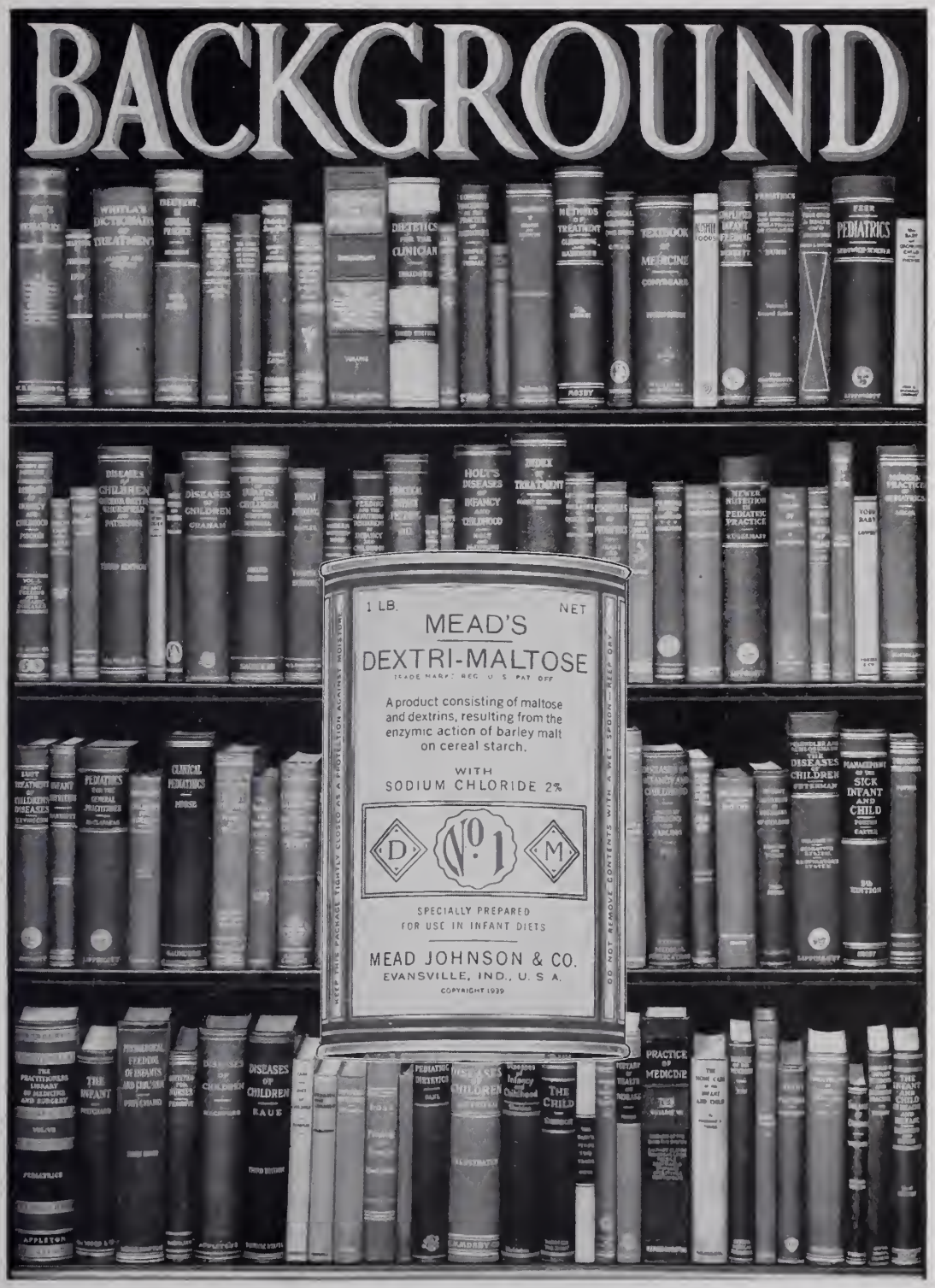
RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses to practice medicine in Wisconsin after passing the examination given by the Wisconsin State Board of Medical Examiners at the Hotel Schroeder, Milwaukee, on June 30, July 1 and 2, 1942.

Name	*School of Graduation*	*Year*	*Present Address*
Alleman, Russell A.	Chicago	1941	Milwaukee County Hospital, Wauwatosa
Angland, Mary H.	Marquette	1942	805 West Yakima, Yakima, Washington
Bassewitz, Paul P.	Wisconsin	1941	2432 North Ninth Street, Sheboygan
Batzle, Joseph H., Jr.	Wisconsin	1940	1432 St. Charles, Wauwatosa
Bonanno, Joseph D.	Marquette	1942	Milwaukee County Hospital, Wauwatosa
Bonniwell, Charles M.	Nebraska	1940	Grandview Hospital, La Crosse
Boxer, Sidney M.	Marquette	1942	908 North Twelfth Street, Milwaukee
Brill, Francis N.	Marquette	1942	Route 2, Elkhart Lake
Bruder, Victor F. J.	Loyola	1937	135 East King Street, Winona, Minnesota
Burchill, Philip S., Jr.	Marquette	1942	107 Ledgeview Avenue, Fond du Lac
Callan, Robert E.	Marquette	1942	6903 West Wisconsin Avenue, Milwaukee
Calvy, Thomas L.	Marquette	1942	248 Elm Street, Fond du Lac
Cervenansky, Andrew A.	Marquette	1942	535 West Walnut, Milwaukee
Cherkasky, Simon	Arkansas	1941	Luther Hospital, Eau Claire
Clifford, Jack E.	Wisconsin	1941	Fort George-Wright, Spokane, Washington
Cohen, Philip P.	Wisconsin	1938	601 South Orchard, Madison
Coontz, Otis H.	St. Louis Univ.	1941	333 Fourth Street, Baraboo
Dessel, Bertram H.	Marquette	1942	Ossian, Iowa
Dohn, H. Phillip	Marquette	1942	831 North Prospect, Milwaukee
Dorn, Anton S.	Marquette	1942	1535-B North Fifteenth, Milwaukee
Earney, Lyman J.	Marquette	1942	1503 Adams Street, La Crosse
Eiriksson, Charles E.	Marquette	1942	Carlisle Barracks, Carlisle, Pennsylvania
Ellingson, Harold V.	Wisconsin	1942	Wisconsin General Hospital, Madison
Feurig, James	Marquette	1942	Seymour
Frankenstein, Norman A.	Wisconsin	1942	2019 University Avenue, Madison
Fruehauf, Richard P.	Illinois	1942	St. Mary's Hospital, Superior
Friedrich, Leland E.	Wisconsin	1941	Lomira
Gauger, Adeline B.	Marquette	1942	2044 North Thirty-fifth Street, Milwaukee
Goodman, Jerome A.	Marquette	1942	931 Grand Avenue, Racine
Hanson, Emmet R.	Marquette	1942	5434 North Thirty-eighth Street, Milwaukee
Harris, Waldo E.	Northwestern	1942	617 North Twenty-third Street, Milwaukee
Hellebrandt, Frances A.	Wisconsin	1929	1715 Jefferson, Madison
Hildebrand, George B.	Rush	1941	125 Locust Street, Reedsburg
Horn, Gilbert O.	Wisconsin	1941	263 Prospect, Oshkosh
Horvath, Daniel C.	Marquette	1942	431 Division Street, Bellevue, Pennsylvania
Hulbert, Bernard	Wisconsin	1941	932 West Lawn, Racine
Hulbert, Sidney Z.	Wisconsin	1941	1517 College Avenue, Racine
Hurie, Robert E.	Illinois	1941	3209 West Wisconsin Avenue, Milwaukee
Hurwitz, Sidney P.	Rush	1941	938 West North Avenue, Milwaukee
Jubelirer, Richard A.	Wisconsin	1941	2839 North Fifty-seventh, Milwaukee
Kammer, Grace E. C.	Wisconsin	1941	Chippewa Falls
Kapke, Franklin W.	Wisconsin	1941	4927 West Ridge Court, Milwaukee
Kaufman, Bernhard	George Washington	1941	Milwaukee County Hospital, Wauwatosa
Kindschi, Donald R.	Pennsylvania	1941	Prairie du Sac
Knudtson, Kenneth P.	Wisconsin	1941	DeForest
Kohn, Louis	Marquette	1942	1945 North Fifth Street, Milwaukee
Kraemer, Willis F.	Wisconsin	1941	5756 Virginia Street, Chicago
Krygier, Albin J.	Marquette	1942	1648 South Eighth Street, Milwaukee
Kuritz, Albert B.	Wisconsin	1941	2820 North Thirty-fifth Street, Milwaukee
Larme, Francis P.	Wisconsin	1941	Belleville
Lochman, David J.	Univ. of Chicago	1941	2705 North Forty-first Street, Milwaukee
Marquis, William R.	Marquette	1942	Waunakee
Mayer, Robert G.	Wisconsin	1941	113 East Fifth Street, Kaukauna
Meyer, Kilian H.	Northwestern	1942	2130 East Locust Street, Milwaukee
McLaughlin, Robert J.	Rush	1941	208 Ryder Street, Wausau
Mirman, Ben	Rush	1941	138 Kent Street, Wausau
Morris, Charles R.	Wisconsin	1941	305 East Fourth Street, Washburn
Murphy, Jack T.	Northwestern	1941	5000 West Chambers, Milwaukee
Murphy, Willis G.	Wisconsin	1941	1934 Monroe, Madison
Nebel, John R.	Wisconsin	1941	298 Washington, Oshkosh
Newkirk, John A.	Marquette	1942	Norway, Michigan
Nezworski, Louis G.	Marquette	1942	Middle River Sanatorium, Hawthorne
Nickelsen, John R.	Wisconsin	1941	Route 3, Box 190, Racine
Orr, Edwin R.	Northwestern	1941	931 Chandler, Madison
Paquette, Louis J.	Marquette	1942	2320 North Lake Drive, Milwaukee
Peckham, Ben M.	Northwestern	1941	2723 North Summit, Milwaukee
Peters, Mendelaus P.	Wisconsin	1941	Spring Green
Prasser, Donald O.	Wisconsin	1941	Wisconsin General Hospital, Madison



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Name	School of Graduation	Year	Present Address
Randolph, Robert C.	Wisconsin	1941	915 North Eighth, Manitowoc
Reed, Howard L.	Duke	1936	1615 Jefferson, Madison
Riegelman, Alida C.	Marquette	1942	2004 North Main, Racine
Robbins, Leonard S.	Wisconsin	1941	Mt. Sinai Hospital, Milwaukee
Schmidt, Charles E.	Wisconsin	1941	2009 East Ivanhoe, Milwaukee
Sexton, Ellen M.	Wisconsin	1941	202 West Avenue South, La Crosse
Shannon, Richard C.	Wisconsin	1941	2749 North Forty-fifth Street, Milwaukee
Shlimovitz, Nathan	Wisconsin	1941	Box 172, Sparta
Shrigley, Edward W.	Wisconsin	1941	Yale Medical School, New Haven, Connecticut
Sikkema, Stella M. H.	Michigan	1941	Wisconsin General Hospital, Madison
Spencer, George N.	Marquette	1942	St. Charles, Minnesota
Tauber, Leo J.	Marquette	1942	1023 North Van Buren, Milwaukee
Taxman, Joel E.	Wisconsin	1941	5018 West Wisconsin Avenue, Milwaukee
Thomley, Miles W.	Wisconsin	1941	Blair
Topp, James H.	Loyola	1942	801 Erie Street, Oak Park, Illinois
Van Ark, Herman F.	Marquette	1942	Milwaukee County Hospital, Wauwatosa
Van Gemert, John G.	Louisville	1941	16 North Carroll, Madison
Willison, Donald M.	Wisconsin	1941	219 West Newhall, Waukesha
Young, William P.	Wisconsin	1941	Route 1, Box 50, Union Grove
Zamil, Edward	Marquette	1942	Carlisle Barrocks, Carlisle, Pennsylvania

The following physicians were granted licenses through reciprocity:

Name	School of Graduation	Previous Address	Present Address
Androp, Serge	Bennett	Ohio	Box A, Wauwatosa
Baird, Homer D.	Pennsylvania	Pennsylvania	Montreal Mining Company, Montreal
Bertucci, Joseph P.	Marquette	Michigan	Ishpeming, Michigan
Brown, Robert C.	Michigan	Minnesota	306 Cherry Street, Green Bay
Burke, John P.	Loyola	Illinois	1059 Loyola Avenue, Chicago
Caron, Walter	Univ. of Illinois	Illinois	800 South East Avenue, Oak Park, Illinois
Chasten, Stephen	Illinois	U. S. Navy	2213 University Avenue, Madison
Cicotte, Frederick J.	Loyola	Illinois	Minocqua
Danziger, Lewis	Johns Hopkins	Maryland	1545 South Layton Boulevard, Milwaukee
Foseid, Oscar F.	Washington Univ.	Missouri	207½ West Wisconsin, Neenah
Holleman, Clarence	Western Reserve	Ohio	433 Greenleaf, Whittier, California
Kelly, Helen J.	Minnesota	Kentucky	1900 East Webster Place, Milwaukee
Knight, Beatrice P.	Texas	Texas	Wisconsin General Hospital, Madison
Leifer, William W.	Tennessee	Tennessee	Wisconsin General Hospital, Madison
Metz, Arthur R.	Rush	Illinois	250 East Superior Street, Chicago, Illinois
Rosen, Theodore S.	Western Reserve	Ohio	Luther Hospital, Eau Claire
Sugarman, Jerome N.	University of Southern California	California	Wisconsin General Hospital, Madison
Waddell, John G.	Cincinnati	Ohio	Mauston
Whipple, Alice B.	Pennsylvania	Pennsylvania	Tower Hotel, Milwaukee
Wilson, John M.	Pittsburgh	Pennsylvania	Wisconsin General Hospital, Madison
Wolcott, W. Eugene	Univ. of Iowa	Iowa	606 Bellin Building, Green Bay
Wong, Victor J.	Louisville	Kentucky	Blanchardville

CORRESPONDENCE

Shorewood Hills
Madison, Wisconsin
September 19, 1942

Mr. Charles Crownhart
State Medical Society of Wisconsin
Madison, Wisconsin

My dear Mr. Crownhart:

The members of the Woman's Medical Auxiliary are most grateful to the State Society for the help it constantly gives to the Auxiliary.

The state office this last year has been of invaluable assistance in countless ways, and especially to the officers of the Auxiliary.

The Buffet Supper at the recent convention, where Medical Auxiliary members were guests of the Medical Society, was one of the high lights of the convention.

Medical Auxiliary members are very eager for the State Society to know its services and kindnesses are really appreciated.

Very truly yours,

(Mrs. W. E.) Caroline Vose Sullivan
For the Woman's Auxiliary to the State Medical Society of Wisconsin

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*Phosphaljel**

WYETH'S ALUMINUM PHOSPHATE GEL

Aluminum hydroxide gel is accepted therapy in the management of peptic ulcer . . . Its impressive record of effectiveness suggested the development of an alternate aluminum preparation to meet particular requirements in certain cases.†

Phosphaljel, Wyeth's Aluminum Phosphate Gel, was originated by Wyeth and was used experimentally in the first successful attempt to prevent postoperative jejunal ulcer in Mann-Williamson dogs. Some animals were allowed to develop Mann-Williamson ulcers and the effectiveness of Phosphaljel was further demonstrated when its administration was followed by prompt healing of these lesions in every case.[1]

In man, Phosphaljel was found to be most effective in peptic ulcer following gastrojejunostomy, a condition which appears to be analogous to the Mann-Williamson ulcer in dogs.[1]

These results suggest that Phosphaljel is indicated in those cases of peptic ulcer associated with a relative or absolute deficiency of pancreatic juice, diarrhea or a low phosphorus diet.

The suggested dosage of Phosphaljel is one, or occasionally, two tablespoonfuls every two hours during the active stage of the ulcer. Later in the course of management, three tablespoonfuls with meals and at bedtime or two tablespoonfuls six times daily with or between meals is recommended. Wyeth's Aluminum Phosphate Gel is supplied in twelve fluid ounce bottles and is available at all pharmacies.

†Phosphaljel is accepted for use in the treatment of peptic ulcer associated with a relative or absolute deficiency of pancreatic juice, diarrhea or a low phosphorus diet.

Phosphaljel contains 4% aluminum phosphate and possesses antacid, astringent and demulcent properties analogous to those of aluminum hydroxide gel.

[1]*Fauley, G. B.; Freeman, S.; Ivy, A. C.; Atkinson, A. J., and Wigodsky, H. S.: Aluminum Phosphate in the Therapy of Peptic Ulcer, Arch. Int. Med. 67: 563-578 (March) 1941.*

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*Reg. U. S. Pat. Off.

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Coming Events

American Public Health Association

The seventy-first annual meeting of the American Public Health Association and related organizations will be held in St. Louis from October 24 to 30. Speakers will include Dr. William D. Stovall, director of the state hygiene laboratory, Madison, who will discuss "Diagnostic Procedures and Reagents." Also scheduled to talk are Dr. William C. Keettel, Jr., Madison, specialist in obstetrics and Dr. Amy L. Hunter, Madison, director of the Bureau of Maternal and Child Health, whose subject will be "How Can Statistical Data Be Used in Planning Maternal and Child Health and Crippled Children's Programs?"

Wisconsin General Hospital Staff Meetings For 1942–43

The meetings will be held on the first and third Tuesdays of the month. To complete the program it was necessary to insert five additional Tuesdays which are neither the first nor the third of the month. They will be held in the Auditorium of the Service Memorial Institute. Attendance is restricted to third and fourth year medical students, internes, residents, hospital and medical school faculty, and interested outside physicians. The first fifteen minutes will be in charge of the housestaff, whose chairman is a member of the Program Committee. Short case reports, brief summaries of interesting work or other similar subjects will be presented. Following this it is proposed to substitute for the usual staff programs twenty lectures selected from the postgraduate series formerly given on Saturday mornings. An endeavor has been made to choose subjects of the most general interest and practical value to students and staff alike. Each lecture is scheduled for a fifty minute presentation which will allow ten minutes for informal discussion from the floor. The meetings will be adjourned promptly at 9 p. m. The University of Wisconsin Medical Society meetings and the various lectures sponsored by the fraternities will be open to the public.

October 20—Dr. Fritz Kant: Psychiatry for the General Practitioner
November 3—Dr. H. H. Reese: Neurologic Disorders Seen in General Practice
November 17—Dr. T. C. Erickson: Head Injuries
December 1—Dr. F. A. Davis: Common Pathologic Conditions of the Fundus of the Eye
December 15—Dr. W. M. Nesbit: Common Office Procedures in the Practice of Ear, Nose, and Throat
January 5—Dr. C. M. Kurtz: Cardiac Problems for the General Practitioner
January 19—Dr. W. H. Oatway and associates: Symposium on Tuberculosis
January 26—Dr. R. E. Burns: Backache
February 2—Dr. E. L. Sevringhaus: The Rudiments of Managing Diabetes and Obesity
February 16—Dr. L. W. Paul: Fundamentals of Gastro-Intestinal X-ray Diagnosis
February 23—Dr. E. R. Schmidt: Problems of Abdominal Surgery
March 2—Dr. I. R. Sisk: The Etiology and Treatment of Renal and Ureteral Stones
March 16—Dr. J. E. Gonce: Some Aspects of Urinary Infection in Infancy and Childhood
March 23—Dr. C. S. Harper: Office Gynecology
April 6—Dr. R. E. Campbell: Carcinoma of the Uterus
April 20—Dr. K. L. Puestow: Sigmoidoscopic and Radiologic Correlation in Diagnosis and Treatment of Colonic Disorders
April 27—Dr. O. O. Meyer: Peripheral Vascular Disease
May 4—Dr. E. A. Pohle: Indications and Contraindications for Roentgen Therapy

Conference on Venereal Disease Control Needs in Wartime

Venereal disease and America's war effort will be discussed by high-ranking medical officers of the War and the Navy Departments, prominent physicians, health officers and others at a conference in Hot Springs National Park, Arkansas, October 21–24. Headquarters will be at the Arlington Hotel.

The Conference will be held under the auspices of the United States Public Health Service in conjunction with the Eighth Annual Meeting of the American Neisserian Medical Society. Surgeon General Thomas Parran will preside. State and local health officers, venereal disease control officers, practicing physicians, and all others engaged in venereal disease control activities are urged to attend.

Subjects for discussion will include venereal disease control measures influencing the war effort, epidemiology of syphilis and gonorrhea—1942, wartime venereal disease control education, research influencing the wartime venereal disease control program, and technics of venereal disease education.

Governmental, professional and health organizations to be represented at the Conference include: the War Department, the Navy Department, the Social Protection Section of the Office of Defense Health and Welfare Services, the American Medical Association, the American Neisserian Medical Society, the American Social Hygiene Association, state and local health departments, and the United States Public Health Service.

Scientific Session of the American Academy of Physical Medicine—Boston, October 14 to 17

The American Academy of Physical Medicine will hold its Twentieth Annual Scientific Session at the Hotel Statler, Boston, October 14 to 17. The program will be composed of clinical and scientific presentations involving technics of importance in wartime medicine.

Topics of the discussions and demonstrations include physical medicine in relation to aviation medicine, physical education, habilitation, rehabilitation, first aid, and war injuries, as well as consideration

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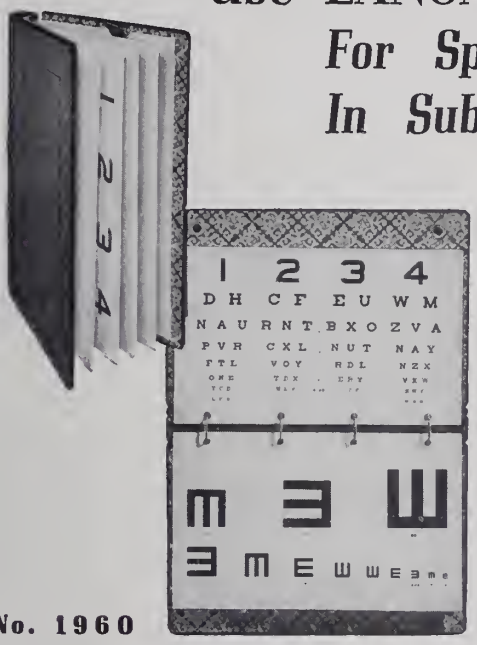

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of the use of physical agents in injury and disease falling within the scope of various medical specialties. There will be symposia on poliomyelitis and electrosurgery. Encephalography, electroshock, fever therapy, and other special procedures will be discussed by outstanding authorities.

Speakers will include pioneers in the development of physical medicine in the earlier World War, physicians actively concerned with military medicine, and leaders in the special medical fields. A clinic will be conducted at the Massachusetts General Hospital. The Academy will have the cooperation of the Massachusetts Institute of Technology and other medical and scientific institutions.

Captain William Seaman Bainbridge, M. C., U.S.N., is the president. The chairman of the Committee on Program is Lieutenant Colonel William D. McFee, M. C., U.S.A.R. Physicians are invited to attend without registration fee. A copy of the official program can be obtained from the secretary-treasurer, Herman A. Osgood, M. D., 144 Commonwealth Avenue, Boston, Massachusetts.

American Board of Ophthalmology

Because of the war emergency, the Board announces the following additional examinations:

New York City—December 13 to 16
Los Angeles—January 15 and 16

At the last meeting it was decided to cancel the 1943 written examination, to include in the oral examination all of the subjects previously covered by the written examination, and temporarily to dispense with the requirement of case reports. The oral examination will probably require two or three days and will cover the following subjects:

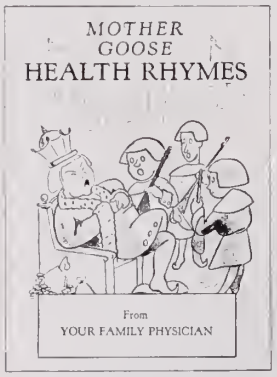
External Diseases—Slit Lamp
Ophthalmoscopy
Histology–Pathology–Bacteriology
Ocular Motility
Refraction—Retinoscopy
Practical Surgery
Anatomy and Embryology
Perimetry
Therapeutics and Operations
Optics and Visual Physiology
Relation of the Eye to General Diseases

Formal application on the proper blanks for the December and January examinations must be filed with the secretary not later than November 1.

Please write at once for blanks to: American Board of Ophthalmology, 6830 Waterman Avenue, St. Louis, Missouri.

Nursery Rhyme Health Message

Nursery rhymes paraphrased to convey a health message are available to physician members at a very nominal cost. Physicians may obtain these by directing their order to the office of the State Medical Society of Wisconsin at Madison. Below is reproduced one of the nursery rhymes which appears in the booklet, together with the note to the parent which appears at the bottom of each rhyme.



Jack and Jill went up the hill
To fetch a pail of water.
Jack fell down and broke his crown
And Jill went for the doctor.

For Jack and Jill are wiser still
Than might have been suspected.
They know that germs make cuts and burns
Dangerous if neglected.

Note to parents: It is important to teach children early that even minor cuts, scratches, and other injuries are possible sources of infection. If the child learns to appreciate the importance of cleansing wounds and rendering first aid while young, he may be spared many unhappy experiences later.

The charge for these pamphlets, based on large quantity printer's cost, is as follows: 100 copies for 6 cents; 200 copies for 10 cents.

SOCIETY RECORDS

New Members

G. F. Burpee, Edgerton.
A. J. Bosse, Ableman.
F. L. Grover, Hartland.
H. C. Wesche, Washburn.
B. I. Bender, Milwaukee.
T. E. Kilkenny, Winneconne.

Changes in Address

T. J. Nereim, Shullsburg, to 3710 Spring Trail, Madison.

P. E. Wright, Manitowoc, to 634 Bowen Street, Oshkosh.

News Items and Personals

Fond du Lac county is the recipient of a portable fracture bed recently presented by the Fond du Lac County Council of the American Legion Auxiliary. Use of the bed will be directed by the Fond du Lac County Medical Society through its president and chairman of its public relations committee.

—△—

Dr. J. F. Bennett, Burlington, has been named physician for the Milwaukee railroad to succeed the late Dr. G. Warren Newell.

—△—

According to an announcement made recently by President Thomas N. Barrows of Lawrence College, Appleton, *Dr. David M. Gallaher* will head the health and hygiene service of that institution beginning with the current semester. He will be assisted by *Dr. James Laird*. Dr. Gallaher is replacing as associate, *Dr. Ralph V. Landis* who recently entered the armed services of this country.

—△—

Dr. Jerry W. McRoberts, on the staff of the Sheboygan clinic and himself awaiting call to active duty, emphasized the important part which the medical profession is playing in this war in an address before the Kiwanis club on September 3.

—△—

Dr. Dennis H. Bruns, Milwaukee, was elected a member of the Aero-Medical Association of the United States at its fourteenth annual meeting at Indianapolis on September 5.

—△—

Dr. Wesley J. Irvine, for fifty years Manawa's country doctor, was honored at a celebration on September 13 in the Manawa high school. More than 500 persons attended.

Dr. Irvine located in Royalton in 1892, moving to Manawa in 1903.

—△—

Three Milwaukee physicians, *Dr. John D. Steele*, *Dr. Oscar A. Sander* and *Dr. Oscar Lotz*, addressed the twenty-ninth annual meeting of the Mississippi Valley Conference on Tuberculosis at the Edgewater Beach Hotel in Chicago on September 16, 17, 18.

Dr. Steele spoke on "Bronchospirometry," Dr. Sander on "Surveying Industrial Personnel," and Dr. Lotz, executive secretary of the Wisconsin Anti-Tuberculosis Association, on "Tuberculin Test and Tuberculosis Control."

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Milwaukee

Society Proceedings

Brown—Kewaunee—Door

The Brown–Kewaunee–Door County Medical Society held a meeting at the Beaumont Hotel in Green Bay on September 10. Following the dinner Dr. Christopher R. Dix, Milwaukee, gave an illustrated talk on "The Repair of Congenital and Acquired Defects."

Dane

At a meeting of the Dane County Medical Society held at the Madison Club on September 8, Dr. Stuart A. McCormick gave a summary of medical contributions to Selective Service in Dane county. Dr. Wendell H. Marsden reported on the gas decontamination project, and Dr. Jack S. Supernaw gave a summary of summer work in Civilian Medical Defense.

Polk

The Polk County Medical Society held its meeting of August 20 at Clear Lake. Dr. William Bernstein of St. Paul, instructor in proctology at the University of Minnesota, showed films on hemorrhoidectomy and discussed some of the common proctologic problems.

Rock

At a meeting of the Rock County Medical Society at the Hilton Hotel in Beloit on September 22, the program committee, all of whom were Janesville physicians, presented a symposium on blood dyscrasias. Dr. William T. Clark spoke on "Leukemias and Lymphoblastoma," Dr. Orrin V. Overton on "Hypochromic Anemias," Dr. M. Meredith Baumgartner on "Hyperchromic Anemias," and Dr. Vincent W. Koch on "Purpuras and Hemolytic Anemias."

Winnebago

Winnebago County Medical Society members attended a dinner meeting September 3 at the Winnebago State Hospital as guests of Dr. Byron J. Hughes, superintendent of the hospital, and members of his staff.

The question of holding child guidance clinics was discussed and several case presentations were given by the staff. It was decided to hold the child guidance clinics, and a committee headed by Dr. Ethan B. Pfefferkorn, Oshkosh, was appointed.

First Councilor District

The First Councilor District meeting of 1942 was held at the Hotel Rogers in Beaver Dam on September 27.

A paper on "Common Allergies" was presented by Dr. William A. Mowry, clinical professor of medicine at the University of Wisconsin Medical School and chief of the allergy service at the Wisconsin General Hospital.

Dr. Morris W. Sherwood, Milwaukee, chairman of the Special Committee on Safety on Public Highways of the State Medical Society of Wisconsin, gave a paper on "Treatment of Automobile Accidents."

Section on Orthopedics

At the annual meeting of the Section on Orthopedics the following physicians were elected as officers for the coming year:

President—R. E. Burns, Madison
Secretary–Treasurer—H. W. Wirka, Madison
Delegate—R. P. Montgomery, Milwaukee
Alternate Delegate—L. D. Smith, Milwaukee

BIRTHS

A daughter, Virginia Jean, to Mr. and Mrs. Charles H. Crownhart, Madison, on September 7.

A daughter to Dr. and Mrs. George L. Boyd, Kaukauna, on August 23.

A son, Robert, to Dr. and Mrs. Cyrus G. Reznichek, Madison, on September 14.

A son, John Elliott, to Dr. and Mrs. Arthur W. Hankwitz, Milwaukee, on August 27.

A daughter, Virginia Marion, to Dr. and Mrs. Milton Trautmann, Prairie du Sac, on September 6.

A son to Dr. and Mrs. Luther E. Holmgren, Madison, September 17.

DEATHS

Dr. John G. Meachem, 96, who was the oldest living graduate of Rush Medical College, and who had practiced medicine in Racine from 1864 until he retired in 1934, died at his home in Racine on September 10. He had been confined to his home for two and a half years and to his bed since January.

Dr. Meachem had resided in Racine since he was sixteen. He was one of the incorporators of St. Luke's Hospital in 1872 and was its first chief of staff. He also was secretary of the hospital board for seventy years, president of the Racine Board of Health, built St. Barnabas Chapel at St. Luke's Hospital in memory of his wife, and endowed the hospital library.

At the time of his death, Dr. Meachem was a member of the Racine County Medical Society, a life member of the State Medical Society of Wisconsin, and the American Medical Association.

Dr. Fayette H. Baldwin, 57, Bloomington physician for nearly thirty years, died at a Milwaukee hospital on August 22.

Dr. Baldwin was born in Lancaster in 1884. He finished his professional training at the Wisconsin

College of Physicians and Surgeons. He started the practice of medicine at Rewey, where he stayed a year, and then moved to Livingston, where he stayed three years. In 1913 he took up residence and practice in Bloomington.

Dr. Baldwin was a member of the Grant County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, two daughters, and a sister.

Dr. Christian H. Beyer, 70, died at his home in Milwaukee on September 4. He was a life-long resident of Milwaukee and practiced there for forty-five years.

Dr. Beyer was graduated from Rush Medical College in 1895.

At the time of his death he was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, three daughters and a son.

Dr. Eugene A. Bergholz, 38, died at his home in Milwaukee on September 5.

After graduating from the University of Wisconsin in 1925 as an electrical engineer, Dr. Bergholz entered Rush Medical College, graduating in 1934. He was the founder of the Bergholz Clinic in Milwaukee.

He is survived by his widow, one daughter and three sisters.

Dr. Julius F. Wenn, 64, died at a Milwaukee sanitarium September 4. He had retired May 1, 1941 because of failing health.

He was born in Chicago and was graduated from Rush Medical College. After three years in private practice he joined the staff of the Kankakee State Hospital, later becoming acting superintendent. He also served as state inspector of private sanitariums in Illinois. He came to Milwaukee in 1910 and was named medical director of St. Mary's Hill in 1912. He was a fellow of the American Psychiatric Association and of the Central Neuropsychiatric Association, a former member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin and the American Medical Association.

He is survived by one sister.

Dr. Bernard A. Becker, 72, of Silver Lake, who practiced medicine in Kenosha and Racine counties for forty-two years, was found dead on September 14 after he was flung from his stalled auto which was struck by a train near Silver Lake.

At the time of his death, Dr. Becker was a member of the Kenosha County Medical Society, the State Medical Society of Wisconsin and the American Medical Association.

He is survived by his widow, two daughters and three sons.

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THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

First Aid to the Injured and Sick. An advanced ambulance handbook. Edited by Norman Hammer, M.R.C.S., major, late R.A.M.C., T.A.; honorary life member, examiner and lecturer, St. John Ambulance Association; county surgeon, St. John Ambulance Brigade; formerly assistant medical advisor, Home Office A.R.P. Department, London. Ed. 18. Paper. Price, $2. Pp. 336, illustrated. Baltimore: Williams & Wilkins Company, 1941.

The eighteenth edition of "First Aid to the Injured and Sick" is an advanced handbook with soft binding and small enough in size to be carried in a person's bag, suit pocket or car pocket. It is an advanced course and contains much valuable information that can be utilized by a physician or medical student right at the scene of disaster. It is very well illustrated. Its only disadvantage is the rather fine type. The reviewer highly recommends this book for doctors, medical students and well trained lay first-aiders. A. R. C.

Starling's Principles of Human Physiology. Edited and revised by C. Lovatt Evans, D.Sc., F.R.C.P., F.R.S., LL.D., Birgmingham; Jodrell professor of physiology, University College, London; with chapters on the special senses revised by H. Hartridge, M.A., M.D., Sc.D., F.R.S., professor of physiology, St. Bartholomew's Medical College. Ed. 8. Cloth. Price, $10. Pp. 1257, illustrated. Philadelphia: Lea & Febiger, 1941.

For thirty years "Starling's Principles of Human Physiology" has been a standard English textbook. In this eighth edition the broad outlines first sketched in by Starling have been retained, but almost every page has been revised to bring the various subjects up to date. The background is supplied by the useful chapters on the structural, biochemical and biophysical principles underlying physiology. The chapters on the nervous system and the special senses are particularly noteworthy. The book is to be recommended both to the medical student and to the practitioner who wish a readable and well illustrated account of physiology as it exists today. W. J. M.

The Pathology of Trauma. By Alan Richards Moritz, M.D., professor of legal medicine, Harvard Medical School; lecturer in legal medicine, Tufts College Medical School; lecturer in legal medicine, Boston University School of Medicine; pathologist, Massachusetts State Department of Public Safety; consulting pathologist, Massachusetts State Department of Mental Health; associate medical examiner of Suffolk County. Cloth. Price, $6.00. Pp. 386, illustrated. Philadelphia: Lea & Febiger, 1942.

The appearance of this new volume is not only timely, but it is predicted that it will become a standard work for pathologists, surgeons, and general practitioners. The book is well written, well organized, cleanly printed, and pertinently illustrated. Well founded pathologic principles are concisely illustrated by relevant details supplied by a patient and keen observer. After a discussion of the results of mechanical injury and the relations of trauma to infection and to tumors, the author reviews mechanical injuries of the cardiovascular system, respiratory system, alimentary canal, other abdominal viscera, urogenital tract, central nervous system, and skeletomuscular system. All types of trauma to all main portions of the body are elaborated, and much valuable information in this heretofore somewhat neglected field is gathered together. The reviewer found so much of interest that he was impelled to read the volume from cover to cover.

The book is recommended for the "active" bookshelf of all physicians who have to deal with the results of trauma. J. C. McC.

Pediatric Gynecology. By Goodrich C. Schauffler, A.B., M.D., assistant clinical professor of obstetrics and gynecology, University of Oregon Medical School; visiting gynecologic surgeon and obstetrician, Multnomah Hospital, Portland, Oregon. Cloth. Price $5. Pp. 384, with 66 illustrations. Chicago: The Year Book Publishers, Inc., 1942.

This book is the first to be devoted exclusively to the disorders of the immature female genitalia and is an excellent treatise on the subject. The author has had extensive clinical experience in this field of gynecology. The text is well written and illustrated. The subject matter includes not only the disturbances of the external and internal female genitalia, but also surgical therapy, special urologic and proctologic considerations. This book will be a great help to every gynecologist, pediatrician and urologist in general practice. M. J. T.

War Medicine. A Symposium. Edited by Winfield Scott Pugh, M.D., Commander, (M.C.) U.S.N. Retired; formerly surgeon, City Hospital, New York; Edward Podolsky, M.D., and Dagobert D. Runes, Ph.D. Cloth. Price, $7.50. Pp. 565, illustrated. New York: Philosophical Library, 1942.

This volume is a compilation of fifty-seven separately prepared articles bearing on the active problems in surgery, medicine and the specialized aspects of these subjects in aviation and naval work. The articles are prepared by men in the military medical services or those who have given especial attention in recent years to the problems of military medicine. There is no attempt at weaving a thread of logic

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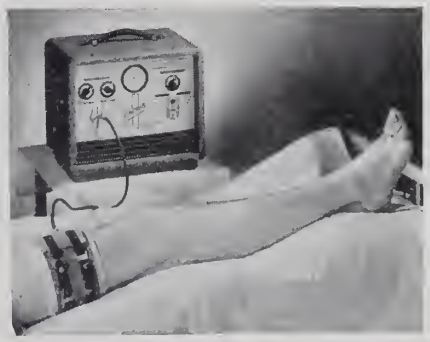

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or uniformity in approach for they are all articles that have appeared elsewhere in the journals of medical science and practice in the last few years. The volume is well printed. The reproductions of illustrations in many cases are only fair because they have been reproduced from half-tones in journals rather than from the originals. Nevertheless, the book will obviously have much of interest to men who are going into military services and have not the background of detailed instructions or experience in this field. Unfortunately, the book has no index, and one has to hunt through the table of contents to find the items in which he is interested at the time. E. L. S.

The Bond Between Us, The Third Component. By Frederic Loomis, M.D., diplomate of the American Board of Obstetrics and Gynecology. Cloth. Price, $2.50. Pp. 267. New York: Alfred A. Knopf, 1942.

This is more than another autobiography of a successful doctor. It is well written, clearly stated, and obviously sincere. The case reports are of considerable interest and show much insight on the part of the author. One finishes the book with the feeling that one has read not only a popularized account of a physician's activities, but that one has been privileged to look within a man's soul. A. C. W.

Carcinoma and Other Malignant Lesions of the Stomach. By Waltman Walters, B. S., M. D., M. S. in surgery, D. Sc., F. A. C. S., surgeon, Mayo Clinic, professor of surgery, University of Minnesota (Mayo Foundation); commander, Medical Corps, United States Naval Reserve; diplomate of the American Board of Surgery; member, National Advisory Cancer Council; Howard K. Gray, B. S., M. D., M. S. in surgery, F. A. C. S., surgeon, Mayo Clinic, associate professor of surgery, University of Minnesota (Mayo Foundation); lieutenant commander, Medical Corps, United States Naval Reserve; diplomate of the American Board of Surgery; James T. Priestley, B. A., M. D., M. S. in experimental surgery, Ph. D. in surgery, F. A. C. S., surgeon, Mayo Clinic, associate professor of surgery, University of Minnesota (Mayo Foundation); major, Medical Reserve Corps, United States Army; diplomate of the American Board of Surgery, and associate in the Mayo Clinic and Mayo Foundation, Rochester, Minnesota. Cloth. Price $8.50. Pp. 576, with many illustrations. Philadelphia: W. B. Saunders Company, 1942.

This book constitutes a comprehensive and detailed analysis of gastric carcinoma from a study of 11,000 patients with malignant disease of the stomach of whom over 6,000 were treated surgically. Although but three names appear as co-authors, the names of several of their associates at the Mayo Clinic appear as contributors to various chapters, so that the book represents an institutional rather than a personal publication.

There are twenty-three chapters including one or more on history, diagnostic procedures, laboratory considerations, physiologic consequences, treatment indications, pre and postoperative care, surgical technics and statistical studies.

It would seem that for information about gastric malignancies one might well refer to this book first. K. L. P.

Treatment in General Practice. By Harry Beckman, M. D., professor of pharmacology, Marquette University School of Medicine, Milwaukee, Wisconsin. Ed. 4, thoroughly revised. Cloth. Price, $10.00. Pp. 1015. Philadelphia: W. B. Saunders Company, 1942.

This new edition maintains the very high standards of previous editions. The work is very complete and includes discussions of many additional diseases. The arrangement and general makeup are similar to that previously employed.

The reviewer knows of no more suitable book on treatment in medicine, and it is justifiably an extremely popular work. The author writes clearly in a pleasant, easy style. This book should certainly be a part of the working library of every practicing physician. O. O. M.

War Gases. Their identification and decontamination. By Morris B. Jacobs, Ph. D., food, drug and insecticide admin., U. S. Department of Agriculture, 1927; chemist, Department of Health, City of New York, 1928; formerly lieutenant, U. S. Chemical Warfare Service Reserve. Cloth. Price, $3.00. Pp. 180. New York: Interscience Publishers, Inc., 1942.

This book is concerned primarily with civilian defense against poison gas and is written for civilian officials whose duties include one or more aspects of this problem. It includes, considering its size, a surprisingly large amount of information concerning toxic gaseous or liquid materials which have been or may be used in war. Adequate references are given for the sources of this information. Several classifications of the different materials are given first, followed by descriptions of the chemical and physical properties and the toxicity of each substance. Later chapters are concerned with the effect on clothes, machinery, buildings and roads and on food and water, on methods of detecting and qualitative and quantitative sampling. Finally, various methods for decontamination of polluted materials

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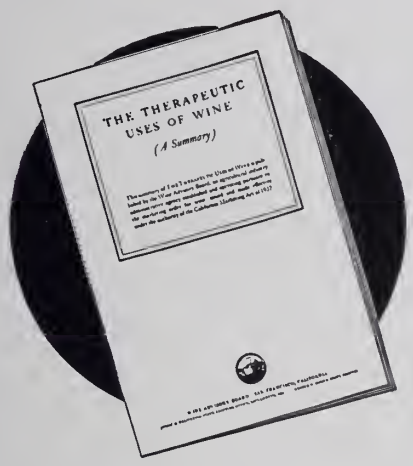

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This review results from a study supported by the Wine Advisory Board, an agricultural industry administrative agency established under the California Marketing Act, and has been sponsored by the Society of Medical Friends of Wine.

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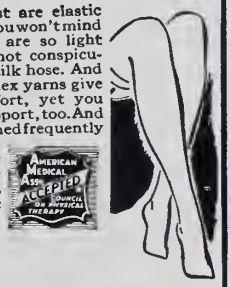

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and regions are described in considerable detail. The book seems admirably suited for the purposes for which it is designed. J. A. E. E.

Collected Papers of the Mayo Clinic and the Mayo Foundation. Edited by Richard M. Hewitt, B. A., M. A., M. D.; A. B. Nevling, M. D.; John R. Miner, B. A., Sc. D.; James R. Eckman, A. B., and M. Katharine Smith, B. A. Volume XXXIII—1941. Cloth. Price, $11.50. Pp. 1099, illustrated. Philadelphia: W. B. Saunders Company, 1942.

This volume contains papers written by members of the staff of the Mayo Clinic and by fellows of the Mayo Foundation during 1941. The 659 articles which form the basis of this volume cover a very wide variety of subjects; sixty-four appear in full, eighty-six by abridgment, sixty-seven by abstract and 442 by title only. Bibliographic references have been omitted from all papers. The editors state that the articles and portions of articles selected for inclusion were those which were thought to be of special interest to the general practitioner, diagnostician and general surgeon. The first eighty-six pages are devoted to articles on aviation medicine and will probably be of wide interest because of the current problems and need for information on this subject. M. L. C.

Blood Grouping Technic. By Fritz Schiff, M. D., late chief of the Department of Bacteriology, Beth Israel Hospital, New York, N. Y., and William C. Boyd, Ph. D., associate professor of biochemistry, Boston University School of Medicine; associate member, Evans Memorial, Massachusetts Memorial Hospitals, Boston, Mass. Cloth. Price, $5.00. Pp. 248, illustrated. New York: Interscience Publishers, Inc., 1942.

The authors of this book have not sacrificed adequacy for brevity but have achieved both in a small but comprehensive text.

The first half of the manual contains a brief discussion of the theory of blood grouping. Acceptable methods for grouping and cross-matching donor and patient and differentiation of the subgroups and factors for which sera are available are described. Consideration is given to the choice of the donor and possible transfusion accidents and their detection. The organization of and the equipment and technics employed in blood banks are discussed.

The second half of the book deals with blood grouping as it concerns forensic medicine, anthropology and the study of genetics. Although a good portion of the latter half is of more academic than practical significance to the clinical laboratorian, it is no less interesting. E. B.

Pathology of the Oral Cavity. By Lester Richard Cahn, D. S. S., associate professor of dentistry (oral pathology), Columbia University, fellow of the American Association for the Advancement of Science, fellow of the New York Academy of Dentistry, associate fellow of the New York Academy of Medicine. Cloth. Price $5.50. Pp. 240. A William Wood Book. Baltimore: The Williams & Wilkins Company, 1941.

Dr. Cahn in his new book, *Pathology of the Oral Cavity*, adequately and briefly covers the lesions of the oral cavity that are commonly seen in everyday practice.

The book is divided into nineteen chapters and each chapter deals clearly with all of the usual problems one meets in dental diagnosis.

Superior illustrations, with clear explanations should be of definite aid in the study and research of oral diseases. L. M. A.

Synopsis of Ano-Rectal Diseases. By Louis J. Hirschman, M. D., F. A. C. S., Ex-Vice President, A. M. A.; Ex-Chairman, Section on Gastroenterology and Proctology, A. M. A.; Ex-President American Proctologic Society; Chairman, American Board of Proctology, Inc., professor of Proctopology, Wayne University; fellow (honorary) Royal Society of Medicine; extra-mural lecturer on Proctology, Post Graduate School, University of Michigan; proctologist, Harper, Charles Godwin Jennings, and Woman's Hospitals; consulting proctologist, Detroit City Receiving, Evangelical Deaconess, Wayne County Hospitals, Children's Hospital of Michigan, Detroit Tuberculosis Sanitarium, Detroit. Ed. 2. Cloth. Price $4.50. Pp. 315, with 182 text illustrations and 12 color plates. St. Louis: The C. V. Mosby Company, 1942.

Devoid of theoretical considerations, historical references and similar material, and emphasizing diagnostic and therapeutic technics, this "Synopsis" amply fulfills its purpose. It has many qualities to recommend itself, both to student and to practitioner. Its author draws upon an experience of about two score years. The material is well organized, easily read, and presented concisely with good print on a high grade of paper in a pocket-size book of over 300 pages. Almost 200, 194 to be exact, illustrations and plates clarify and embellish the text. A timely chapter on "Focal Infections of Ano-Rectal Origin" has been added along with a complete revision of the first edition. It should find its greatest use as a guide in office proctology. K. L. P.

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**The Military Surgeon, Vol. 89, No. 1, p. 5, July, 1941*
J.A.M.A., 93:1110—October 12, 1929
Brückner, H.—Die Biochemie des Tabaks, 1936

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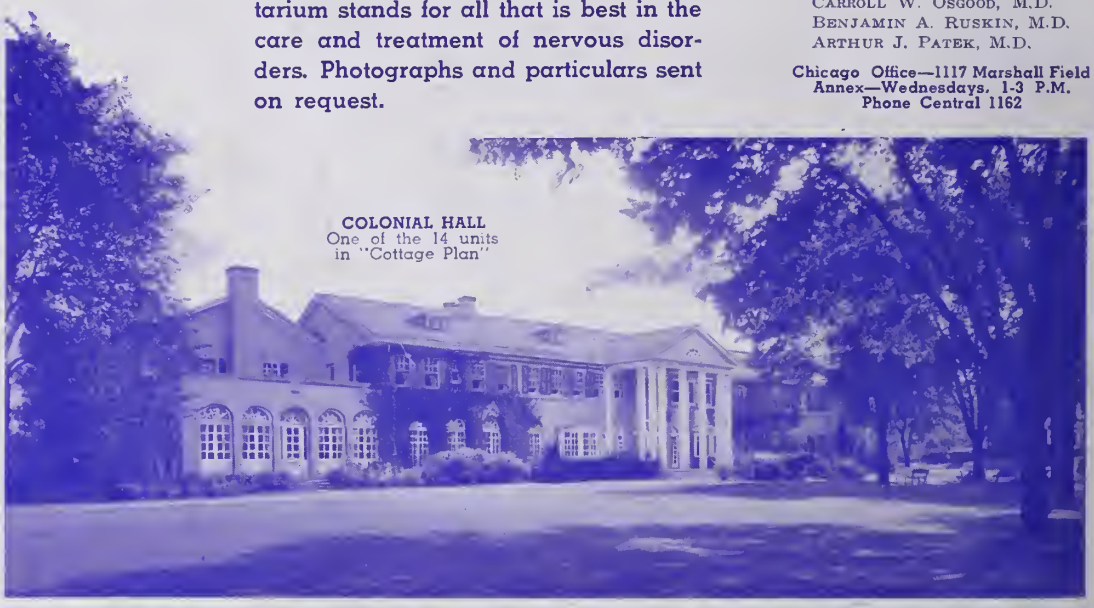

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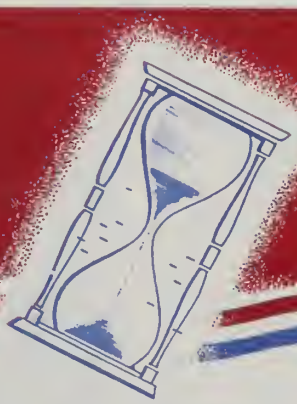


KEEP 'EM WORKING

MILWAUKEE

November 17

Under The Auspices of
The Committee on Industrial Health
and
The Council on Scientific Work
of
The State Medical Society of Wisconsin
in Cooperation with
The Industrial Hygiene Unit
State Board of Health

KEEP 'EM WORKING

POSTGRADUATE

INDUSTRIAL MEDICAL and SURGICAL CLINIC

Hotel Schroeder, Milwaukee, November 17

WISCONSIN physicians on the home front have been charged with the responsibility of keeping our war industries and farm production workers at work. The Council on Scientific Work has appropriately selected as its theme for the postgraduate industrial medical and surgical clinic the motto: "Keep 'Em Working."

Farm workers form as important a link in our war industries as do the men at the lathe or on the assembly line. To maintain an uninterrupted flow of food to the fighting forces and to the workers is a vital function of the farmers of Wisconsin. The farmer must produce the supplies necessary to keep our war industries moving. Farmers suffer skull injuries, traumatic shock and fractures, and have back pain just as do the men in the factories. Returning the farmer to his work as rapidly as possible is as vital to our war effort as returning the foundry man. To keep both the farmer and the factory man at work is the responsibility of Wisconsin physicians. Attainment of this goal requires administration of the highest type of medical care and application of the most recent developments in the treatment of occupational injuries and diseases.

The Conference Committee on Open Panels, which originally conceived the presentation of industrial health postgraduate medical education, was motivated by the thought that the wide choice of physician, made possible through the open panel, obligated the profession to maintain medical care at an ever-increasing high standard.

The Council on Scientific Work, mindful of this responsibility, has carried to completion the recommendation of the Conference Committee on Open Panels that there be conducted a special postgraduate clinic on industrial health. Dr. Francis D. Murphy, a member of the Council on Scientific Work, was assigned to prepare the program. After consultation with the Committee on Industrial Health and the Conference Committee on Open Panels, the topics for the clinic were selected, and speakers secured who are best able to bring tested scientific information on the subject to Wisconsin physicians.

R. D. MURPHY, M. D.

Speakers obtained by Dr. Murphy for the "Keep 'Em Working" postgraduate industrial medical and surgical clinic are: Drs. Merritt L. Jones, Wausau; James R. Regan, Milwaukee; Elston L. Belknap, Milwaukee; Raymond W. McNealy, Chicago; Chester C. Schneider, Milwaukee; Carl W. Eberbach, Milwaukee; Harry W. Sargeant, Milwaukee; Erwin R. Schmidt, Madison; Harry E. Mock, Chicago; Eben J. Carey, Milwaukee; Newell C. Gilbert, Chicago; Herman C. Schumm, Milwaukee; John O. Dieterle, Milwaukee; Stephen E. Gavin, Fond du Lac; John L. Garvey, Milwaukee; William E. Grove, Milwaukee; and Mr. Andrew T. Court, Detroit.

Through the cooperation of the Industrial Hygiene Unit of the State Board of Health it will be possible for the Council on Scientific Work to present the first postgraduate industrial medical and surgical clinic without the customary registration fee charged to defray expenses of similar one day sessions.

Mark November 17 on your calendar as reserved for the postgraduate industrial medical and surgical clinic.

PROGRAM

MORNING

General chairman—Dr. Gunnar Gundersen, La Crosse, chairman, Committee on Industrial Health

9:00– 9:10 Introduction by the chairman outlining the significance of this meeting.

9:10– 9:30 The Physician's Responsibility Under the Workmen's Compensation Act
Mr. Harry A. Nelson, director, Workmen's Compensation Division, Industrial Commission.

9:30– 9:50 The Evaluation of Disability in Industrial Injuries.
Dr. Merritt L. Jones, Wausau

9:50–10:10 Knee Joint Injuries and Their Treatment.
Dr. James R. Regan, Milwaukee

10:10–10:20 Recess.

10:20–10:40 Poisons in Industry
Dr. Elston L. Belknap, assistant clinical professor, Marquette University School of Medicine, Milwaukee

10:40–11:00 The Handicap of Hernia in Industry.
Dr. Raymond W. McNealy, associate professor of surgery, Northwestern University Medical School, Chicago

11:00–11:20 Reduction of Disabilities in Fracture Management.
Dr. Chester C. Schneider, Milwaukee

11:20–11:40 Traumatic Shock.
Dr. Carl W. Eberbach, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee

11:40–12:10 Hospital Facilities and Inadequacies during the Accelerated Program.
Dr. Harry W. Sargeant, superintendent, Milwaukee County Hospital, Milwaukee

KEEP 'EM WORKING

Time is precious. Time lost by workers and farmers helps the Axis. Help lick the Axis by helping to reduce absence from work. Attend the postgraduate industrial medical and surgical clinic in Milwaukee on November 17.

KEEP 'EM WORKING

12:10—1:45 ROUND-TABLE LUNCHEONS

1. The Standard Outline Used in Estimating Disability
   Dr. Merritt L. Jones, Wausau
   Parlor C
2. Injuries and Dislocation of the Shoulder
   Dr. James R. Regan, Milwaukee
   Parlor D
3. Poisons in Industry
   Dr. Elston L. Belknap, Milwaukee
   Parlor E
4. Crushing Injuries to the Feet
   Dr. Chester C. Schneider, Milwaukee
   Parlor F
5. Traumatic Abdominal Injuries
   Dr. Raymond C. McNealy, Chicago
   Parlor I
6. Wounds of Soft Parts and Their Management
   Dr. Carl W. Eberbach, Milwaukee
   Room B
7. Skull Fractures
   Dr. Harry E. Mock, Chicago
   Room C
8. The Coronary Artery in Industry
   Dr. Newell C. Gilbert, Chicago
   Room D
9. Rehabilitation Following Fractures
   Dr. Herman C. Schumm, Milwaukee
   Room E
10. The Physical Examination in Industry
    Dr. Russell M. Kurten, Racine
    Committee Room

AFTERNOON

2:00– 2:20 Injuries to the Scalp, Skull and Brain.
Dr. Erwin R. Schmidt, professor of surgery, University of Wisconsin Medical School, Madison

2:20– 2:40 Refrigeration Anesthesia in Amputations.

Anatomical and Constitutional Aspects in Differential Diagnosis of Low Back Pain.

Dr. Harry E. Mock, Chicago

2:40– 3:00 Anatomical Considerations in Back Injuries.

Dr. Eben J. Carey, dean and professor of anatomy, Marquette University School of Medicine, Milwaukee

3:00– 3:20 Heart and Industry.

Dr. N. C. Gilbert, professor of medicine, Northwestern University Medical School, Chicago

3:20– 3:30 Recess.

3:30– 3:50 Common Fractures and their Treatment.

Dr. Herman C. Schumm, associate professor of orthopedic surgery, University of Wisconsin Medical School; clinical professor of orthopedic surgery, Marquette University School of Medicine, Milwaukee

3:50– 4:10 Intervertebral Disc Diseases.

Dr. John O. Dieterle, Milwaukee

4:10– 4:30 Therapy of Burns.

Dr. Stephen E. Gavin, Fond du Lac

4:30– 4:50 Neuritis Following the Use of Serum.

Dr. John L. Garvey, clinical professor of neurology, Marquette University School of Medicine, Milwaukee

4:50– 5:10 Ear and Eye Complications of Cranio–Cerebral Injuries.

Dr. William E. Grove, Milwaukee

7:00 Banquet

Health in Industry.

Mr. William D. James, president, James Manufacturing Company, Fort Atkinson

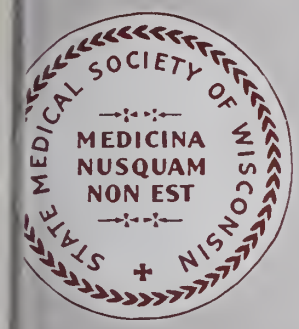
Sickness Absenteeism in Industry.

Mr. Andrew T. Court, General Motors Corporation, Detroit.

KEEP 'EM WORKING

Every man-hour lost by the worker and the farmer hinders our war effort. Do your part to reduce worker absenteeism. Attend the postgraduate industrial medical and surgical clinic in Milwaukee on November 17.

KEEP 'EM WORKING



Keep 'Em Working
Postgraduate Industrial
Medical and Surgical Clinic
TUESDAY, NOVEMBER 17
Hotel Schroeder, Milwaukee

The Wisconsin Medical Journal

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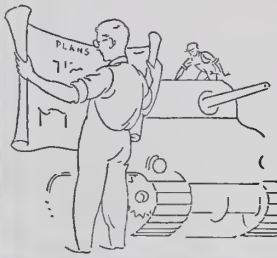

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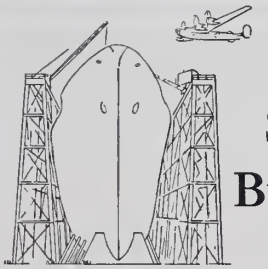

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"Acceptance for mailing at special rate of postage provided for in Section 1103, Act of October 3, 1917. Authorized Aug. 7, 1918."

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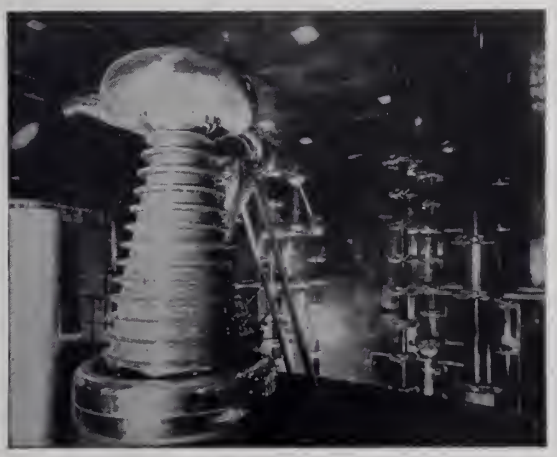

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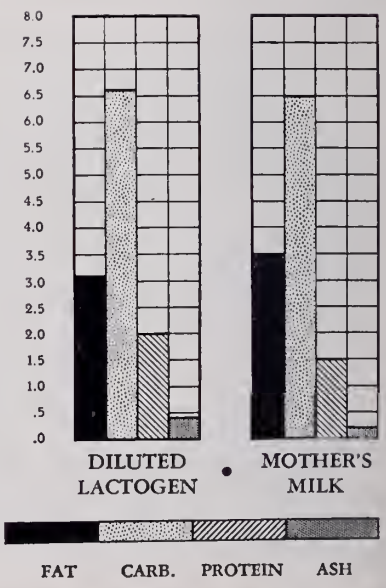

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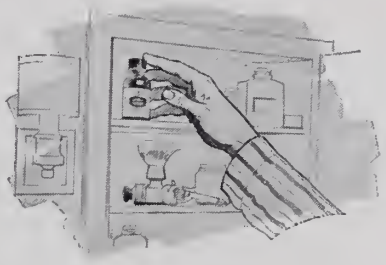

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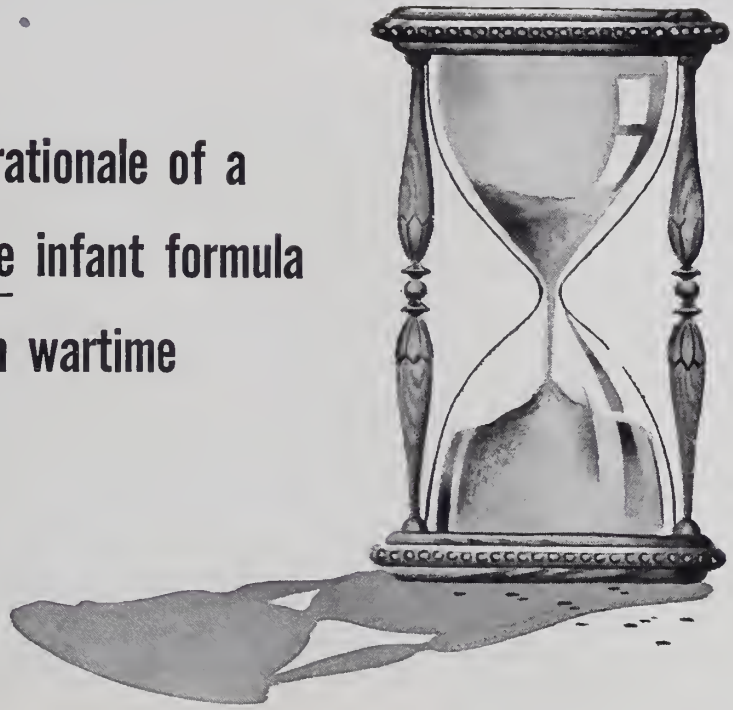

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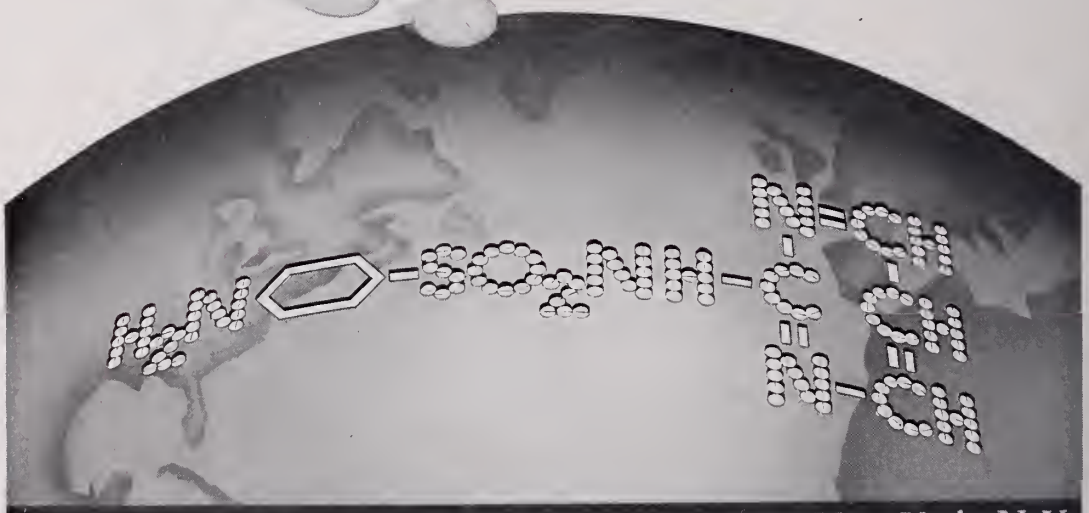

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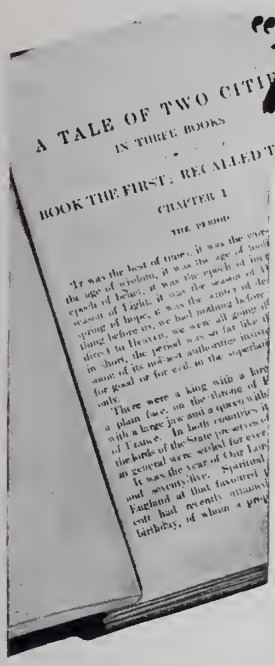

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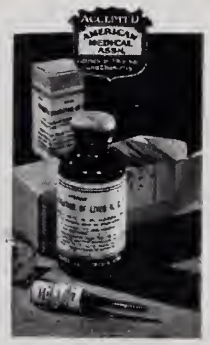

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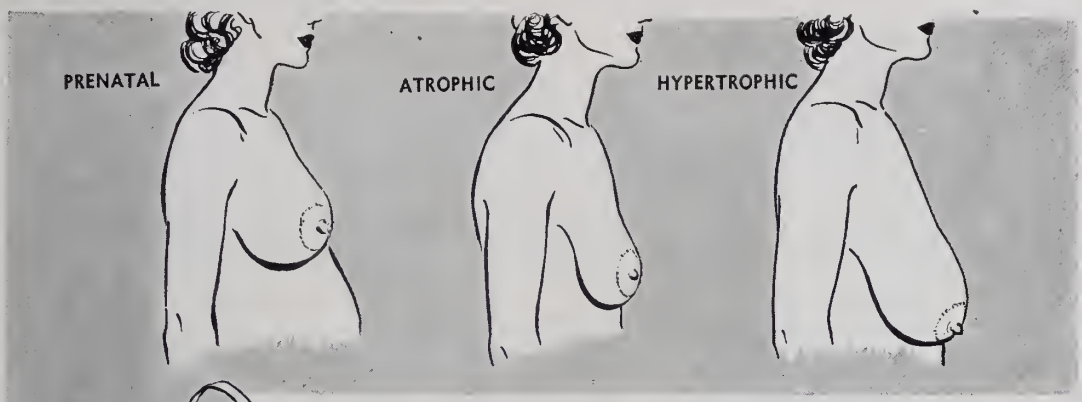

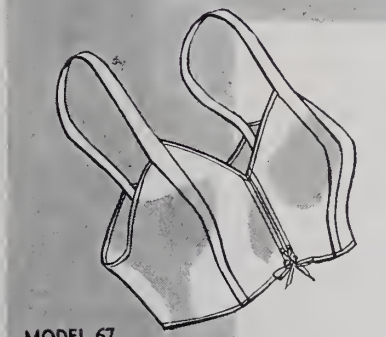
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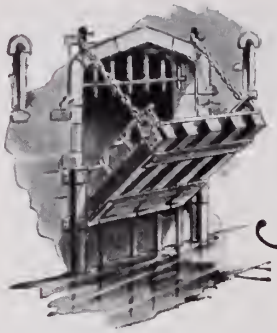

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VOLUME 41, NO. 11 Copyright, 1942, by The State Medical Society of Wisconsin NOVEMBER, 1942

The Incidence of Atmospheric Mold Spores in Relation to Climatic Conditions in Milwaukee, 1935-1941

By THERON G. RANDOLPH, M. D., and THEODORE L. SQUIER, M. D.

Milwaukee

DURING the last decade sensitivity to fungous spores has been recognized as a significant cause of seasonal inhalant allergy. Because the production and dissemination of mold spores in sufficient numbers to cause allergic symptoms are largely dependent upon flora, moisture and winds, it is reasonable that the clinical importance of mold allergy might vary in different geographic areas. The impression is held by those living in the region of the Great Lakes that mold sensitivity is second only to pollen sensitivity as an etiologic factor in seasonal inhalant allergy, and that of the various atmospheric spores encountered, Alternaria is by far the chief offender.

The first instance of Alternaria sensitivity as the cause of asthma was reported by Hopkins, Benham and Kesten[1] in 1930, although prior to this time other fungous spores had been associated with the etiology of asthma and hay fever.[2,3,4] Feinberg[5,6,7] in 1935 and 1936 pointed out the dominant role of Alternaria in fungous inhalant allergy and clearly demonstrated the relationship of allergic symptoms and the incidence of mold spores in the atmosphere. His observations have been repeatedly confirmed. Durham[8] and others[9,10,11] have made extensive surveys of the atmospheric mold spore counts in the region of the Great Lakes and elsewhere.

We have made atmospheric mold spore surveys in Milwaukee during each summer from 1935 through 1941, using the regular gravity slide method.

Vaseline coated microscope slides were exposed daily for twenty-four hours from April 1 to December 1. A slide was placed on the roof of an eight story office building located approximately three-eighths of a mile from Lake Michigan in downtown Milwaukee. The slide was protected from direct rainfall by a cover six inches in diameter held three inches above its surface. The spores in the conventional area of 1.8 sq. cm. were counted, and the resulting figure was regarded as representing the number of spores per cubic yard of air.

Alternaria spores, because of their large size and distinctive club shape, may be identified readily and counted by direct observation of the gravity slide. Other air-borne spores of recognized importance in inhalant allergy cannot be as accurately counted, and consequently their enumeration from the gravity slide was not attempted.

The seven year cumulative total Alternaria count (1935 through 1941) is represented graphically in Figure 1. The Alternaria counts have shown variations from year to year largely dependent upon differences in rainfall and winds. However, there are distinctive features of the typical Alternaria season which are brought out in clear relief by the cumulative totals shown in Figure I.

1. Although sufficient Alternaria spores to cause symptoms may occasionally be present prior to July 15, this is unusual. Ordinarily a sharp increase in the incidence of spores is observed in mid-July, and this rise is as-

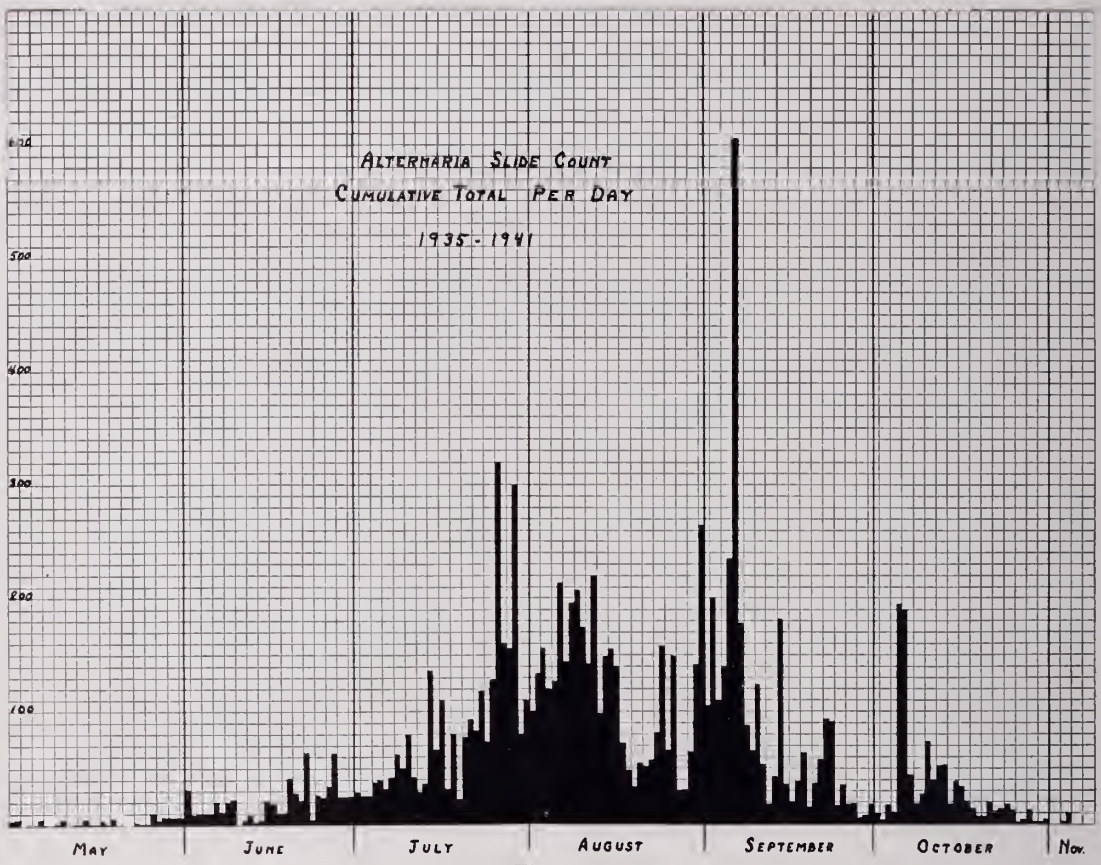

Fig. 1.

sociated with definite clinical symptoms in Alternaria sensitive patients. In the interval between the grass and ragweed seasons in late July and early August the pollen content of the air is negligible, and it is in this interval that clinical Alternaria symptoms are so striking that frequently a presumptive diagnosis of sensitivity may be made from the history.

2. In the cumulative graph it can be seen that there is a tendency during the last half of August for the Alternaria counts to be somewhat lower. Comparison with rainfall records shows that quite regularly this is a relatively dry period.

3. The maximum Alternaria peak for the season sometimes occurs during the last few days of August but more commonly in early September, often simultaneously with the maximum ragweed count. Therefore, it is obvious that a patient sensitive both to ragweed and Alternaria may have symptoms from each, and that failure to recognize Alternaria sensitivity and to treat such patients with Alternaria will give poor results. Occasionally patients also are seen who are sensitive to Alternaria alone and who have been regarded and erroneously treated as ragweed sensitive.

4. The cumulative graph also shows that there is usually an Alternaria peak during the first ten days in October. This unquestionably contributes to postseason symptoms in ragweed patients who are also Alternaria sensitive, although it by no means accounts for all of the difficulties seen after the close of the ragweed season.

These features are all apparent in the graph of the daily Alternaria counts for the 1941 season (Figure 2). It is to be noted that in the period from July 15 to October 15 the higher counts occurred on days when the wind was blowing with relatively high veloc-

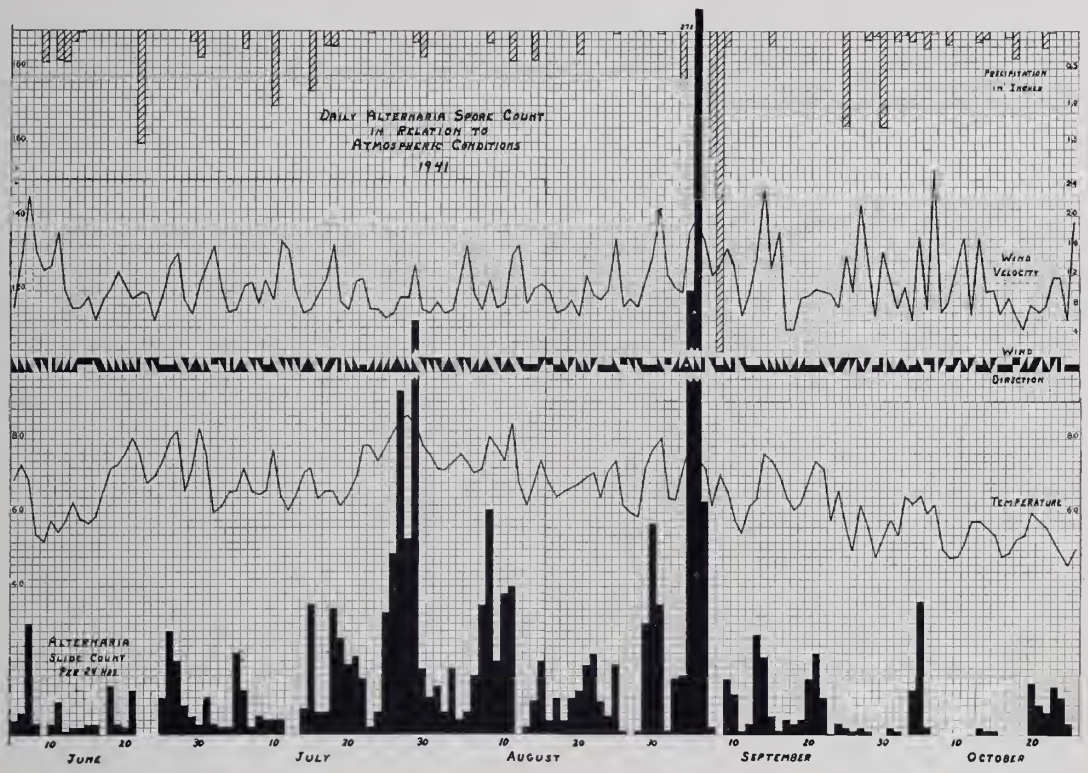

Fig. 2.

ity from the southwest, west or south. Lower spore counts were associated with winds coming from over Lake Michigan, that is, from any eastern quarter.

On September 5, 1941, there was an unusually high Alternaria spore count of 272, representing the highest count during the seven year period of this survey. The weather conditions existing at that time are of special interest. The wind from the southwest averaged nineteen miles per hour and reached a maximum velocity of thirty-nine miles per hour. This high wind came from areas in which there had been extremely heavy rainfall for three and four days previously. The mean and maximum precipitations are shown in Table I.

Similar weather conditions have preceded the peak Alternaria counts of other seasons. In 1940 the maximum count of 144 on August 30 was associated with a west and southwest wind which reached a maximum velocity of twenty-eight miles per hour. A three day rainy period to the west and southwest of Milwaukee was followed by dry, warm weather lasting two to three days immediately preceding this 1940 peak.

Since direct gravity slide spore counts give only a partial picture of atmospheric mold contamination, additional surveys were made by the culture plate method during the summers of 1939, 1940 and 1941.

A standard sized Petri's dish containing potato-dextrose agar was exposed for five minutes at 8:00 a.m. daily in the same location as previously described. Colony identification was made during the fourth to tenth day after exposure.

Alternaria counts obtained by this method were found to agree in general with those from the gravity slide method. The variations which existed could be explained by the differences in the wind velocity and direction at the time the plate was exposed in contrast to the twenty-four hour velocity and direction. The results of this three year survey are shown in Figure 3 each plotted point representing the cumulative total per week for three years.

TABLE I

AVERAGE PRECIPITATION IN INCHES, SEPTEMBER, 1941

Day	1		2		3		4		5	
	Mean	Max.	Mean	Max.	Mean	Max.	Mean	Max.	Mean	Max.
Central Kansas	0.16	3.03	1.34	8.31	0.17	1.58				
Central Nebraska	0.09	2.00	0.46	1.51	0.20	1.65				
Eastern Kansas	0.46	2.79	0.51	4.15	0.04	0.93				
Eastern Nebraska	0.07	1.27	0.70	3.15	0.63	3.60				
Northern Missouri	0.15	2.20	0.42	4.10	0.56	3.25				
Western Iowa			0.22	1.76	0.43	1.44	0.05	0.83		
Central Iowa			0.76	3.07	0.71	3.93	0.02	2.25		
Eastern Iowa			0.15	2.48	0.40	2.19	0.29	1.15		
Northern Illinois					0.34	1.43	0.01	1.72	1.26	3.70
Southern Wisconsin					0.26	0.66	0.34	1.22	0.19	0.85

It is apparent that the general contour of the Alternaria curve is quite similar to that in Figure 1. The sharp rise in mid-July, the late August drop, the September peak and the post ragweed mold peak in October, previously discussed in relation to the gravity counts, are again demonstrated in this chart.

Slightly more colonies of Hormodendron than Alternaria were observed. The maximum Hormodendron count occurred in early August with significant secondary peaks in June and October. Clinical sensitivity to Hormondendron is apparently of distinctly secondary importance in comparison with Alternaria sensitivity.

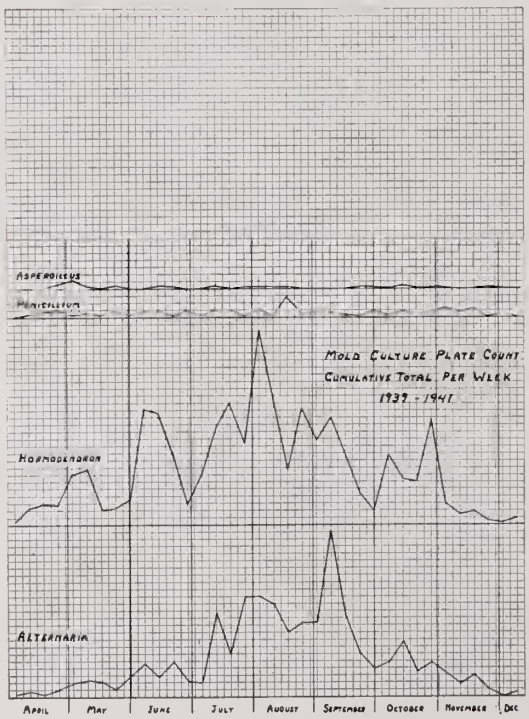

Fig. 3.

All other molds appeared to be of minor significance, and the curves for Penicillium and Aspergillus only are shown. Non-spore producing colonies such as "sterile mycelium" and others were not plotted since thus far they have not been shown to be of significance in relation to inhalant allergy.

In atmospheric mold surveys spore counts made by the gravity slide method have the advantage of simplicity. One slide serves for both pollen and spore counts and represents the entire twenty-four hour period. By contrast, the culture plate method is cumbersome and provides data for only a few minutes of each day, which may or may not be truly representative of conditions prevailing during the twenty-four hour period.

The incidence of spores other than Alternaria may best be determined by culture methods; the gravity slide method appears entirely adequate for the latter which appears to be of greatest importance in inhalant allergy.

Summary

The seasonal atmospheric Alternaria spore count in Milwaukee determined by the gravity slide method is reported for the years 1935 to 1941 inclusive and compared with determinations made during the seasons of 1939, 1940 and 1941 by potato-dextrose agar

cultures. Alternaria spores, the chief cause of inhalant fungous allergy, are present in relatively large numbers from mid-July to mid-October, ordinarily reaching a peak coincident with the ragweed pollen peak in early September. Maximum Hormodendron counts occurred early in August with significant secondary peaks in June and October.

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Bronchitis*

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A DISCUSSION of bronchitis can be given with more unity and clarity by considering separately the acute and chronic forms.

Acute Bronchitis

Acute inflammation of the bronchial tubes is a common disease. Usually it involves the trachea also and should more properly be designated as tracheobronchitis.[1] Although it may be found in all regions, the disease is prevalent especially in cold, damp climates. It occurs frequently during seasons in which there are sudden changes in temperature. Persons of all ages may have the disease, but it seems to have an affinity for infants and aged individuals.[2]

Etiology: Sometimes acute bronchitis is due to irritating gases, including ether, or dusts, but usually it is of infectious origin. The organisms usually found are Micrococcus catarrhalis, Streptococcus, Staphylococcus, and Pneumococcus. The influenza bacillus may also be present. Mixed infection is most common.[2] Less frequently the disease may be due to a spirochete. Exposure to cold and fatigue and poor ventilation are contributing factors. Often the disease follows rhinitis or pharyngitis. It is very contagious and sometimes prevails in epidemic form.[3] It may occur secondarily in the course of general infectious diseases, such as measles, whooping cough, influenza, and typhoid fever.[2]

Varieties: From the clinical standpoint it is not possible to separate groups of bronchitis to correspond with the chief infective agent.[3] However, to simplify the discussion of acute tracheobronchitis the following varieties may be considered: the simple, the asthmatic, and the spirochetal. The simple and the asthmatic varieties may be due to one organism or a combination of the organisms mentioned above, while spirochetal bronchitis is caused by a spirochete.

Symptoms: At the onset, the patient usually experiences chilliness, lassitude and general muscular soreness. The fever is slight. A cough is always present, but it varies in severity. When the cough is pronounced it may cause chest pain and headache. When the cough becomes looser and the expectoration more plentiful the symptoms quickly subside.[2]

* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

Physical Signs: In the simple form of acute bronchitis scattered mucous râles are heard throughout the chest. The asthmatic form is characterized by loud musical râles with moderate wheezing and dyspnea. The term asthmatic is used because the symptoms and signs are somewhat similar to asthma. Spirochetal bronchitis has mucous râles similiar to those of the simple form.

Diagnosis: In differential diagnosis bronchopneumonia must be considered. However, in this disease the symptoms are more pronounced, the fever is higher, cyanosis and dypsnea are present, and examination of the chest shows areas of dullness. At the onset whooping cough may be similiar to acute bronchitis, but its identity is soon made evident by the characteristic cough accompanied by vomiting. Bronchitis that is resistant to the usual methods of treatment should make one suspicious of tuberculosis. This is particularly true if there is an afternoon rise in temperature and if the pulmonary signs are unilateral or confined to the apices. Also the possibility of the bronchial involvement being a part of a disease such as influenza, measles or typhoid fever should be considered.[2]

Prognosis and Course: The usual duration of the disease in healthy individuals is one to three weeks. An extension of the process downward with the development of bronchopneumonia is a dreaded complication. This may occur in young children and in the aged.[3] In these cases the prognosis must be guarded.[2]

Treatment: Rest in bed is advisable until the temperature has remained normal for at least twenty-four hours. A light nourishing diet should be given. Fluid in the amount of 2,500 cc. daily is desirable. Of this amount, approximately one half should be fruit juices. Mild laxatives can be prescribed as necessary. Codeine is helpful for the relief of cough and pain. While the patient is resting in bed, a dose of one-fourth of a grain of codeine and five grains of acetylsalicylic acid may be administered every four hours. In addition, a cough mixture such as the following is useful in simple bronchitis:

	Gm. or Cc.	
Rx Ammonium chloride	6.00	ʒ iss
Codeine phosphate	0.26	grs. iv
Syrup of tolu q.s.ad.	120.00	fl. ℥ iv

M. Sig.: One teaspoonful every four hours.

Elixir terpin hydrate with codeine usually is effective also. For the asthmatic form, steam inhalations with menthol or compound tincture of benzoin are helpful. For this form also a different type of cough mixture is usually necessary. Ochsner's asthma mixture gives good results. It loosens the cough and makes the expectoration more abundant. This surely is a shotgun prescription but, as a rule, is very effective.

	Gm. or Cc.	
Rx Sodium iodide	10.00	ʒ iiss
Potassium iodide	10.00	ʒ iiss
Tincture of belladonna	20.00	fl. ʒ v
Tincture of Hyoscyamus	20.00	fl. ʒ v
Tincture of Lobelia	20.00	fl. ʒ v
Fluidextract of Grindelia		
Fluidextract of Glycyrrhiza		
Syrup of tolu aa q.s.ad.	250.00	fl. ℥ viii

M. Sig.: One teaspoonful in water four times daily.

Pepper and Ham report the use of sulfathiazole in four cases. In three cases Pneumococcus was found and in the fourth case, Streptococcus viridans. In all the cases of pneumococcic bronchitis there was prompt improvement. An initial dose of 3 Gms. was given followed by a second dose of 3 Gms. in four hours. Thereafter, 1 Gm. was given every four hours until treatment was discontinued. Usually it was continued for two or three days, after the temperature had fallen to normal. Sulfanilamide may be useful in some cases. Hess treated 2 cases of spirochetal bronchitis with good results. In 1 case therapy consisted of weekly injections of mapharsen and, in the other, intramuscular bismuth.

Chronic Bronchitis

Chronic bronchitis may follow repeated attacks of acute bronchitis, or it may result from continued inhalation of irritating dusts or vapors. However, it is usually a secondary process in the course of other affections of the respiratory tract, chronic heart disease, chronic nephritis or gout.[2] It is the cause of the winter cough of the aged which recurs regularly with cold and changeable weather. The organisms are practically the same as

in acute bronchitis and are often in combination.[3] Often chronic bronchitis is associated with infection in the upper respiratory tract, such as sinusitis. In children infected tonsils and adenoids are important in regard to etiology. The "cigarette cough" of the intemperate smoker may be due to chronic bronchitis.[4]

Varieties: As with acute bronchitis, it is difficult to separate chronic bronchitis into groups with reference to etiology. From the clinical standpoint, the following varieties may be considered: the simple, the asthmatic,[5] the spirochetal, the mycotic and the allergic.[6] The simple and the asthmatic forms may be due to one organism or a combination of the organisms mentioned in the discussion of acute bronchitis. The asthmatic form resembles asthma only in respect to the wheezing, the slight dyspnea, and the musical râles. The spirochetal form, as is evident, is caused by a spirochete, and the mycotic form may be due to various fungi. According to Vadalá, the fungi usually are: (1) yeastlike organisms, Cryptococci, Oidia, Monilia, Saccharomyces and Endomyces, and (2) filamentous forms, such as the Actinomyces group. Mycotic infection of the lungs is more prevalent than is generally suspected. The allergic form is due to a peculiar sensitivity of the individual to certain materials.

Special Forms

Several special forms of chronic bronchitis may be distinguished by the quantity and character of the sputum. Bronchorrhea is so designated because of the profuse secretion which is sometimes more than a pint a day. Purulent bronchorrhea is usually associated with bronchiectasis. In cases of serous bronchorrhea, there are frequently violent paroxysms of cough and asthma-like attacks of dyspnea. Fetid bronchitis is a rare form in which the secretions undergo putrid decomposition. It is usually associated with bronchiectasis.[2] There is also the catarrh sec of Laennec, which is fairly common and is characterized by severe paroxysms of coughing with little or no expectoration. It usually occurs in elderly people with emphysema. Sometimes fibrinous casts are coughed up, and the condition is called fibrinous bronchitis.[3]

Symptoms: Cough and expectoration are the chief symptoms. There may be dyspnea on exertion, and it is usually caused by some associated condition, such as emphysema, asthma or cardiac insufficiency.[2] Slight dyspnea may be observed also in the asthmatic and allergic forms of bronchitis. The cough is often paroxysmal, is more troublesome at night, and is especially severe in cold, damp weather. The sputum is usually abundant and mucopurulent. The symptoms of the mycotic form are essentially as outlined. There may be slight fever. There also may be loss of weight, hemoptysis, and sputum of nauseating foul odor.[7, 8] In the allergic form the cough is relatively unproductive. In this form also secondary anemia and eosinophilia are common.[6]

Physical Signs: The findings often are not pronounced. Musical or mucous râles frequently are heard. If there is emphysema also, the chest is enlarged, and movements of the chest are slight. The percussion note is hyperresonant, the breath sounds are distant, and expiration is prolonged.[2] Crepitant râles are common at the bases.[3]

In children, these symptoms of chronic bronchitis are commonly found in association with enlarged tonsils and adenoids, sinusitis, and sometimes enlarged bronchial glands. The child often is thin and underdeveloped and is a mouth breather.[3]

Complications: Pulmonary emphysema develops in prolonged cases. Bronchiectasis is a common complication. In fetid bronchitis, bronchopneumonia and gangrene of the lung may occur.[2] Chronic cor pulmonale may result from the long continued increased resistance in the lungs.

Diagnosis: The diagnosis usually is not difficult. A complete examination should be performed to determine whether the disease is primary or secondary.[2] In the spirochetal form, spirochetes are found in the sputum, and in the mycotic form, fungi are found. In the differential diagnosis, pulmonary tuberculosis, heart disease, bronchiectasis, foreign bodies in the bronchi, pneumonoconiosis, lung abscess, bronchial asthma, and

bronchogenic carcinoma should be considered. The sputum should be studied thoroughly, and roentgenograms should be taken.[2, 3, 4] Iodized oil may be used when necessary for differentiation. The bronchoscope plays an important part in diagnosis.[4]

Prognosis: The disease is fairly well tolerated by the patient for many years under favorable conditions. Complete recovery is rare except in the early stages.[2]

Treatment: In prophylaxis, sources of infection, such as sinusitis, chronic tonsillitis, enlarged adenoids, and dental sepsis should receive prompt and adequate treatment. It is well known that they may be forerunners of the disease.

Change of Climate

In the treatment of the disease an attempt should be made to prevent the recurrence of attacks. Whenever it is possible, change of climate in winter is highly desirable. Arizona, New Mexico, Southern California and Florida have suitable climates. If the patient is unable to go to a better climate, he should stay indoors as much as possible in bad weather and take every precaution against exposure.[2]

The diet should be nutritious. It should be adequate in vitamins.

Any chronic disease which exists should receive proper treatment. If there is heart disease, the patient should be placed on an appropriate program. Anemia should be treated with iron and, if necessary, liver. Cod-liver oil or a similar preparation should be given. If there is evidence of renal involvement, the diet should be regulated and other treatment instituted.

For the simple form, a program of treatment as outlined in the discussion of acute bronchitis is useful. The ammonium chloride cough mixture or elixir terpin hydrate with codeine may be prescribed. In some cases, potassium iodide is of service. Sulfathiazole should be given a trial.[9]

The asthmatic form is usually helped by the use of steam inhalations with menthol or compound tincture of benzoin and Ochsner's asthma mixture. This prescription will be found in the discussion of the treatment of acute bronchitis. Autogenous or stock vaccines sometimes are of use.[5] For autogenous vaccine, it is well to obtain the material for the preparation of the vaccine by bronchoscopy.[2]

The spirochetal form usually responds well to neoarsphenamine, mapharsen, or bismuth. Hess treated two cases with good results as noted previously.

Mycotic bronchitis or bronchomycosis should be treated as early as possible. The process may extend into the lungs and adjacent tissue. Stovall and Greeley suggest large doses of potassium iodide and roentgenographic therapy. In the bronchopulmonary stage, the condition may be amenable to surgery if other treatment has failed.[8] Usually the treatment of choice is irradiation combined with the use of iodides or surgery.[8]

In the treatment of allergic bronchitis, it is imperative to eliminate the important allergens, and prompt relief often results. When the condition is due to house dust, yeast and molds, or pollens, desensitization is the most effective form of treatment. Potassium iodide sometimes is of help in relieving the cough.[6]

For nonspecific forms of bronchitis, the injection of iodized oil into the bronchi is sometimes very beneficial in cases which have not responded to other measures. In 1922 Sicard and Forestier used this procedure for the first time. They used it for the purpose of diagnosing bronchiectasis. Some of us were fortunate enough to hear Forestier present his paper here at the university shortly afterward. Tewksbury and Fenton report the use of lipiodol in the treatment of chronic bronchitis. They advocate giving iodides by mouth for a short time to rule out the possibility of sensitivity to iodine. For the first treatment they use 1 cc. on each side. It is well to check up by fluoroscope and roentgenogram before and after treatment. This is done to determine the condition of the bronchial tract, to confirm the presence of oil in the tubes, and to determine the amount of retained oil from the previous treatment. The contraindications are active pulmonary tuberculosis, acute infection, and

myocardial weakness, especially with pulmonary edema. Tewksbury and Fenton use as a local anesthetic 2 per cent pantocaine 1.5 cc. They drop it on the base of the tongue and permit it to flow into the larynx. In 29 cases of simple bronchitis this treatment was employed. In 9 cases, relief was obtained; in 8 cases, much improvement; in 9 cases, improvement; and in 3 cases, no improvement. They feel that the use of small doses of iodized oil in the bronchial tract is a safe procedure and a distinct advance in treatment.

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Contact Infections in Childhood, Particularly Tuberculosis*

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THERE are two possible methods of approaching the problem of prevention of infectious diseases: one is the negative attitude of avoiding contacts, the other the positive of preparing for future contacts. Both of these methods, the one of hygienic isolationism as well as the other of immunologic interventionism, have their definite place in the prevention of diseases.

Isolation and Immunization

The first logical reaction to the discovery of the causative micro-organism of an infection was to put up a "no trespassing" sign to every known source of infection. In a certain group of epidemic diseases this proved adequate in limiting, and in some instances stopping, the propagation of the disease. This still holds true, for instance, for the typhoid group, as well as for the bacillar and amebic forms of dysentery, for cholera, and finally for the venereal diseases.

However, in other bacterial or virus infections like diphtheria, streptococcic, meningococcic and pneumoccocic diseases, in whooping cough and measles, in common cold, smallpox, poliomyelitis and encephalitis, the bacteriologic police protection alone proved disappointing. Two factors are chiefly responsible for the ineffectiveness of isolation: either the recognition of the danger during the less characteristic prodromal stage proves difficult like in smallpox, measles, and whooping cough; or apparently healthy bacteria or virus carriers are found in such large numbers that isolation of these sources of infection comes either too late or proves technically unfeasible.

A striking example of the impracticability of isolating the carriers is the epidemiology of meningococcic meningitis. The occurrence of healthy carriers ranges from about 2 per cent between epidemic periods to as high as 38.5 per cent in times of epidemic.[1,2]

Regarding diphtheria there is a similar variation of about 1 per cent of virulent Klebs–Löffler bacilli in all healthy throats in

* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

New York City, according to W. H. Park,[3] to 36.6 per cent in contact cases.

In pneumococcic infections Smillie[4] found that the number of healthy carriers of the virulent type I varies between one out of 500 average persons to every eighteenth contact case.

In the abortive form of poliomyelitis the virus may be excreted as long as four months after a mild illness of two days' duration.[5]

The contagiousness of the common cold through contacts in the very earliest stages has been studied by Dochez[6] and Smillie.[7]

According to Simon[8] it is estimated that 25,000 typhoid carriers are living in New York City. The frequency of the findings of hemolytic streptococci in the pharynx of children with and without tonsils has been stressed by Van Dyke[9] and D. J. Davis.[10]

In some of these acute infectious diseases the complete elimination of every source of infection is a practical impossibility, while in others it is a proposition of sanitary control of food and water supply.

Immunologic interventionism, in other words active and passive immunization, makes it possible to safeguard contacts against the danger of infection regardless of exposure. By reducing the incidence of the clinical disease itself the march of epidemics can be halted and the invading enemy eventually disarmed or destroyed, as it has happened in smallpox, diphtheria, and to a certain extent in whooping cough, typhoid fever and cholera.

Tuberculosis Contact

In no other epidemic disease do we face as challenging a problem as in tuberculosis. It is in many ways a simpler, less ambiguous epidemiologic proposition than the ones presented by most other infectious diseases. In tuberculosis, as well as in syphilis, we do not admit the existence of healthy carriers. We consider the finding of certified tubercle bacilli on an individual definite proof, not only of the infectiousness, but also of the activity of the underlying pathologic process.

Therefore, the approach to the problem of tuberculosis contacts does not have to be made from the bacteriologic angle alone, but through early and complete diagnosis of the disease itself. The discovery of one open case serves oftentimes as the first clue for the detection of an entire hideout of tuberculosis. On the other hand, the first case of a group to be found may be a child, sometimes just a positive tuberculin reactor in the course of a routine survey. A subsequent scrutiny of the entire family may lead to the discovery of a highly infectious adult phthisis as the original or parent source of infection, possibly with numerous endemic ramifications within the family or the professional and social culture medium.

The importance in a case finding program of following the track from contact to contact is obvious. The point in question at the present time is the practicability of mass tuberculin testing in schools and institutions for the discovery of active cases either among the individuals tested or among their family contacts. The results of such surveys carried out with the proper technic of multiple, quantitative tests, followed by roentgenograms of the positive reactors, have been found somewhat meager considering the time, effort, and costs involved. Chadwick[11] found one case of active pulmonary tuberculosis for every 1,200 children tested. Among 669 children roentgenographed in the age group from six to ten years Edwards found no case of pulmonary tuberculosis. Hetherington, McPhedran et al[12] found 0.19 per cent manifest tuberculosis among 2,654 primary school children tested and 0.5 per cent of those roentgenographed.

One of the most thorough surveys reported recently is the one by the City of Chicago Municipal Tuberculosis Sanitarium and the Cook County Tuberculosis Hospital under the direction of Frederick Tice.[13] Of 167,345 grade and high school children who were tuberculin tested, 27,401, or 17 per cent, reacted positively. Reinfection type tuberculosis was found in only 1.3 per 1,000 tested cases, but in 9.26 per 1000 roentgenographed. The cost of this case finding program per capita of active tuberculosis was stated to be $511.95. However, Plunkett,[14] in a similar survey, computes the fantastic amount of $4,419 per case.

The report of the City of Chicago Municipal Tuberculosis Sanitarium draws this

Fig. 1. L. L., 17 years, attended school with far advanced tuberculosis.

Fig. 2. M. K., 16 years, attended school with far advanced tuberculosis.

very striking conclusion: "Why work a low-grade ore when rich ore is available and easily accessible to the case finding machinery?" By rich ore is meant evidently the greater frequency of contact cases around a chance discovery of tuberculosis.

Yet a community program of tuberculosis eradication among school children cannot very well depend entirely on these chance discoveries. Considering the insidiousness and the scarcity of symptoms of the childhood and adolescent type of tuberculosis, routine examinations by the school physician and even by the family physician oftentimes prove inadequate to prevent a tragic delay in the recognition and isolation of an active case.

Here are three illustrations of the failure of early recognition of far advanced pulmonary tuberculoiss in three girls from three different high schools of Milwaukee County.

L. L., seventeen years. Father died of tuberculosis six years ago. Developed a slight cough seven months ago which persisted, slight loss of weight, no other definite complaint. Attended school regularly until one week ago. Diagnosis on examination pulmonary tuberculosis, bilateral, far advanced, sputum Gaffky five, prognosis hopeless.

M. K., sixteen years, no family history of tuberculosis. Under treatment for diabetes mellitus for seven years. Felt quite well until six weeks ago when she began to lose weight and strength and developed a hacking cough. Attended eleventh grade class until four days before admission to sanatorium. Diagnosis: Pulmonary tuberculosis, bilateral, far advanced, sputum positive on direct smear, prognosis hopeless.

C. P., fifteen years, sister died of tuberculosis two years ago, a brother a former patient. Attended school regularly until two months ago when she developed fever, night sweats, loss of strength, and a slight cough. Diagnosis on admission pulmonary tuberculosis, bilateral, far advanced, prognosis grave.

There is no doubt that the only way of preventing reinfection tuberculosis from developing and deteriorating into a far advanced stage is to be ever suspicious of it, even where it does not exist. It is better to be a hundred times wrong in suspecting it, than to be wrong only once in not suspecting it.

The next step after the suspicion of tuberculosis has arisen is roentgenography. This is still considered by many physicians to be somewhat of an extravagance. But as a matter of fact there is a definite trend at present to make photo-fluorography a procedure of

Fig. 3. E. F., 32 years, reviewed for ten months after diagnosis of pulmonary tuberculosis was made at home and at work.

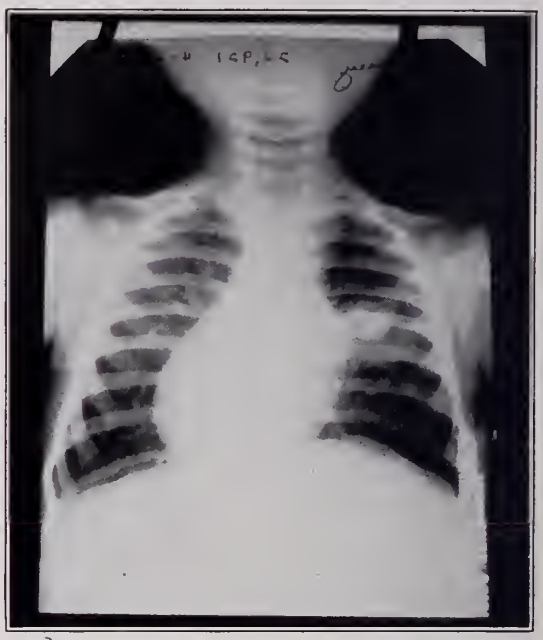

Fig. 4. W. F., 2½ months old, became infected by father soon after birth.

more or less universal applicability. The above mentioned Chicago report figures the cost of a miniature three by four inch film as 5 cents. There is no doubt that this method, if applied generally to school children and also adult groups, would do more than any other single measure in detecting dangerous contacts and removing them from public circulation.

Family Contact

The family is a more important factor in the development of tuberculosis in children than school and other outside contacts. In the preschool age it is logical to expect familial infections to be the rule and extrafamilial contacts the exception. Outside tuberculosis contacts grow in importance as the child outgrows the home and becomes incorporated into the community life.

There are few figures available as to the relation between familial and extrafamilial infections. Blatt and Greengard[15] give 30 to 40 per cent as the role family contact plays among the tuberculous children at Cook County Tuberculosis Hospital.

In order to get a better insight into this rather important epidemiologic question we analyzed 200 children admitted to Muirdale Sanatorium to determine the presence or absence of contacts within the immediate family.

To our surprise, family contacts in our group played a much larger role than we had anticipated. While the average of 78 per cent seems unusually high, this figure is arrived at not only on account of the younger age group, but also because of a more or less even distribution throughout the entire childhood up to fifteen years.

In breaking down the figures for every year of life, the five year group shows the highest incidence of family infection, 100 per cent, and the twelve year group the lowest, 55 per cent. The following explanation might seem somewhat farfetched but may possibly give the proper answer. Infants and preschool children of the lower classes are temporarily left more often in the care of neighbors or strangers, while the four and five year old ones are in the most intimate association in play and work with the entire family. After eight years the incidence of outside infections is found on the upgrade, but it never reaches the figures for family contacts.

	AGE															
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	Totals
Family contacts	8	4	8	6	14	10	12	12	28	12	17	6	9	7	5	158
Percentage	77. 5	67	80	75	78	100	86	86	80	70	85	55	82	78	63	78
No family contacts	1	2	2	2	4	0	2	2	7	5	3	5	2	2	3	42
Percentage	12. 5	33	20	25	22	0	14	14	20	30	15	45	18	22	37	22

As to the inefficacy of the customary procedure in trying to prevent further contact after a diagnosis of open active phthisis has been made the following case report may serve as a drastic illustration:

E. F., 32 years, brewery worker, began to cough September, 1939. A November diagnosis showed pulmonary tuberculosis, moderately advanced, sputum positive. Instead of accepting treatment at sanatorium he took up Christian Science. The brewing company re-employed him in December although notified about his condition. On March 11, 1940, his wife gave birth to an infant, W. F. On May 27, 1940, this child was admitted to Milwaukee Children's Hospital with high fever, brassy cough and expiratory stridor. Mantoux test, 0.01 mg., was strongly positive, a chest roentgenogram revealed an extensive post primary tuberculosis in the right lung. On June 13, 1940, he was transferred to Muirdale Sanatorium, and on July 22, 1940, ten months after diagnosis, the father E. F. finally agreed to enter the sanatorium as a far advanced case.

The outcome of this survey makes it appear still more urgent to concentrate on persuasive, and if possible legislative, measures to eliminate diseased carriers of tuberculosis from their families and from their entire social environments.

Summary

Most infectious diseases are transmitted through human contact with diseased or healthy carriers of the infective micro-organism. The problem of healthy carriers complicates the task of prevention.

In the case of common colds, streptococcic, pneumococcic, and meningococcic infections, in poliomyelitis and encephalitis, healthy carriers are so prevalent, or in case of epidemics more or less ubiquitous, that systematic isolation proves impractical. On the other hand, the prodromal and subclinical stages of the actual disease are oftentimes so difficult to recognize, that the quarantine door is being locked after the contagion has already stolen away.

Therefore, in acute infectious diseases the attempt to dry up the sources of infection has to be supplemented, wherever possible, by active and passive immunization. Only then can we expect to achieve success as in smallpox, diphtheria, whooping cough, typhoid fever, and cholera.

In the prevention of tuberculosis everything depends on the detection and isolation of the infectious carrier. We do not admit the existence of a healthy carrier in tuberculosis. The presence of any open lesion testifies to the activity of the disease, no matter how well concealed, behind a front of apparently perfect health. Unrecognized or "incognito" tuberculosis is the greatest danger for childhood contacts.

The examination of tuberculosis suspects by roentgenogram and finer sputum tests, including gastric lavage cultures, is eliminating more tuberculosis carriers from public circulation.

The most important source of infection for children is still the family. Out of 200 cases of childhood tuberculosis at Muirdale Sanatorium 158, or 78 per cent, had a history of family contact. The age group with the highest incidence of family contacts is from five to eight years, the lowest at eleven years.

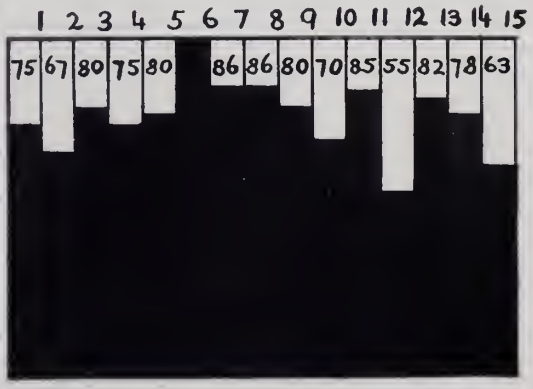

Fig. 5. Percentage of family contacts in 200 children, 78 per cent.

The task of reducing further the incidence of childhood infections consists mainly in following the course of a familial infection upstream to its source, which is the open active adult case, and drying it up before more human soil becomes contaminated.

Discussion

K. B. McDonough, M. D., Madison: Upper respiratory infections are of great importance because they are world-wide in prevalence, attack each individual usually more than once a year, are costly in time and health, and, though usually benign, may be the first manifestation of an infection which is ultimately fatal. The common cold is the greatest single cause of illness and probably constitutes the largest part of pediatric practice.

The cause of the so-called common cold, or upper respiratory infection, is generally conceded to be a filterable virus. Bacteria may be regarded as secondary invaders and perhaps play a major role in the etiology of many of the complications. Cultures of the nose and throat secretions of individuals with colds do not show a variation in number or type of organisms from those found in the nasopharynx of normal individuals. Those most frequently found are the Staphylococci, Streptococci, Pneumococci, Micrococcus catarrhalis and bacillus influenzae. Webster and Crow have shown that carriers of Streptococci, Pneumococci, and the bacillus influenzae show an increase in number during acute upper respiratory disease. When the nasal secretions become mucopurulent in the later stages, the number of colonies increases. In spite of the evidence for virus infection as the primary cause with secondary invasions by various pyogenic organisms, it is conceivable that the common cold may be caused by a variety of bacteria. We have all seen an increased incidence of upper respiratory disease during epidemics of measles, whooping cough, and scarlet fever and have often wondered whether or not many of these infections were a coincidence or due to various specific causative agents. It is not an uncommon experience to find a case of roseola infantum developing in a household in which the older members have ordinary colds, explosive tonsillitis, or laryngo-tracheitis. Perhaps the common cold is not a clinical entity but a symptom complex which includes many infections of a similar nature.

The study of the epidemiology of upper respiratory disease is difficult because it is so common, of such brief duration and, usually, so mild. Then, too, colds are clinically poorly defined. If mild and limited to the nose we use the term coryza and if extension to adjacent structures occurs we call the infection a sinusitis, bronchitis, or laryngitis. When constitutional symptoms occur such as fever, aching, and lassitude, we use the term "grippe" or influenza.

The incidence of upper respiratory disease is greatest under the age of five years and complications are more frequent in this age group. Infants under six months of age are least often infected probably because of a certain amount of natural immunity and less likelihood of exposure to older children. There seems to be a certain amount of immunity developed to familial or household bacteria. Contact with persons outside of the home, in nursery schools, grade schools, churches, moving picture shows or with part time domestic servants, nurses or doctors more often results in infection. Transmission is usually by droplet infection and is perhaps to some extent airborne. Indirect contact may occur in such infections as septic sore throat or Vincent's angina.

Difficulty in the control of contact infections of the upper respiratory tract is due in great part to the fact that they are so widespread and occur so frequently. The physician and family are usually discouraged from efforts to isolate the affected person or persons because of the difficulty in enforcing such isolation. Nevertheless, the responsibility of protecting infants and children lies with them. The task of educating the public to the danger of common colds and to its responsibility in the protection of others, particularly the young as well as themselves, lies with the members of the medical profession. Isolation of individuals with upper respiratory infections lessens the dangers of spread to others and protects the patient from secondary infection with invaders such as the Pneumococcus and hemolytic Streptococcus. All persons with colds should remain at home in bed for two or three days in order to protect themselves and others. Infants and children with colds should be isolated from visitors and from other members of the family as much as possible.

There are no adequate specific measures for the prevention of upper respiratory infections, although autogenetic and stock vaccines have been tried with conflicting results. High vitamin intake, particularly of vitamins A and C, may increase resistance to these infections, but clinical experimental results are not promising. It would seem that avoidance of contact, maintenance of normal nutrition, with an adequate diet and supplementary vitamins, prevention of fatigue and exposure to cold are the best measures available to us at present. Certainly the child who is well nourished and receives plenty of sleep and rest is more likely to be resistant to these infections. Care in clothing these children properly, in preventing wet feet and overexposure, particularly in cold, damp weather, avoidance of overcrowding, and maintenance of normal heat and humidity in the home will result in a lower incidence of colds. In institutions for the care of children admission or observation wards, isolation units, restriction of visitors, and unit technic in the care of infected cases by nurses and physicians will help reduce the incidence and spread of the common upper respiratory infections which so often become extremely virulent in hospitals and orphanages. Ultraviolet irradiation of the air in wards and cubicles may prevent the spread of airborne infections and has proved useful in contagious units.

The adequate treatment of common upper respiratory infections will do much to lower the incidence of serious, acute complications such as sinusitis, bronchiectasis, otitis media, mastoiditis, pneumonia and meningitis. Since nephritis, arthritis and rheumatic heart disease so often are manifested after apparently simple colds and sore throats, these diseases should be regarded as potential dangers and are an added incentive to our prescription of proper treatment. When a child develops a cold, bed rest should be maintained if possible, but, if the child cannot be kept in bed, he should be kept indoors at least and be kept occupied in quiet play during the acute phase. It is important to examine the child, especially if he has a fever, paying particular attention to the throat and ears in order to anticipate and forestall, if possible, serious complications. Since the development of chemotherapy with the sulfonamides, we have a potent weapon with which to prevent many of the complications of upper respiratory disease which may be crippling or fatal to infants and children.

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Epilepsy in Childhood

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IDIOPATHIC epilepsy is a chronic disease of the brain characterized by periodically recurring convulsions, lapses, or abnormal mental states which occur in an individual with an inherited constitutional defect. I present my revised definition of this well known disease entity to make clear my conception of the subject. While epilepsy is one of the convulsive states, it remains a distinct and separate disease entity, well recognized in medicine and diagnosed only by exclusion from the various other organic conditions or diseases which produce convulsions. In my previous definition of this disease I included the phrase "but with no demonstrated pathologic lesion."[1] Since then the electroencephalographic studies have consistently revealed abnormal tracings in epileptics.[2] While no gross or microscopic pathologic changes have been demonstrated in patients with pure epilepsy, the abnormal electric changes, registering a difference in potential in various areas of the brain, must have some permanent abnormal basis. Hence, I would now make this change in my definition.

Heredity

The electroencephalogram has established proof of the inheritance of the constitutional defect. Patients with symptomatic convulsions, that is, convulsions with some organic basis, have three times as many near relatives with epilepsy as do those with some nonconvulsive disease. Patients with essential epilepsy have five times as many. In a series of 46 patients in which electroencephalographic records were made of both parents, there was only one instance in which both parents had entirely normal records. This is the first substantiation of the long-

held clinical contention that epilepsy is an inherited disease.[3]

In my series I have found that the disease is transmitted as a Mendelian recessive.[4] It may skip several generations, or potential epileptics may die before the first seizure, or, what is perhaps more common, we may never obtain a complete and reliable history in many cases. It is rare to find more than one active case of epilepsy in a family, that is, in the siblings or in the parents of the epileptic.[5] It is estimated that one half of 1 per cent of the population suffers from active epilsepsy. This makes a large group of about 650,000 individuals in the United States who suffer from this disease. The epileptic has five times as great a chance of transmitting his disease as has the non-epileptic.

While epilepsy is an inherited disease, its expectancy among the progeny cannot be accurately prognosticated. Many individuals who have inherited an epileptic constitution never develop the clinical manifestations of the disease. These appear only after some disturbance in metabolism initiates the cycle. This disturbance does not usually take place until the child is past three years of age (average three to eight years). The epileptic child has not usually had convulsions in infancy. Once his disease sets in it is usually relentlessly progressive unless treatment is instituted.

Diagnosis

While epilepsy is one of the oldest diseases in medical literature, the cause is unknown. The diagnosis is not difficult and is usually made from the history. After the convulsions have recurred several times, their stereotyped character becomes apparent. A positive diagnosis cannot be made from the history of one or two convulsions. The seizures usually appear without warning in a healthy child of normal or above average intelligence. A subnormal intelligence at the onset suggests an organic cause for the convulsions.

Shortly after the seizures become established about half of the children with grand mal develop aurae. In most cases, however, with or without evident aurae, the mother soon learns to anticipate a seizure by a change in the child's behavior, sometimes a day or two before the event. This change cannot be recognized except by the mother. The first scientific substantiation of any mental or physical alteration was reported by Krasnogorski in 1930.[6] He stated that in epileptic children the conditioned reflexes were held in abeyance or suppressed as long as thirty-six hours before a convulsion. Recently Gibbs and his associates have demonstrated that definite changes occur in the electroencephalographic tracings several hours before a convulsion.[7]

The grand mal seizures may occur any time in the day or night. They are slightly more frequent at night or early in the morning before awakening. The petit mal seizures are recognizable clinically only when the patient is awake but occur also during sleep. It is not necessary to detail the descriptions of the types of seizures. After eliciting a detailed description of the convulsions the physician must carefully review the birth and the past history. Every effort must be made in the history and in the examination to eliminate every possible organic cause of the convulsions. The family history must be reviewed repeatedly to uncover a background or source of the disease. Any history of difficult labor or delivery, any history of cerebral injury or infection, particularly of neurologic symptoms following an infectious disease, is presumptive evidence that subsequent convulsions are probably not due to epilepsy.

The physical examination of the epileptic usually reveals no significant abnormalities. There is no characteristic sign or finding which distinguishes the patient with this disease. However, the physical and the neurologic examinations must be thorough and complete to eliminate any possible organic cerebral lesion. As in every neurologic case, a blood Wassermann test and a spinal fluid examination should be made. I have found several surprises in the spinal fluid. Calcium, phosphorus and blood sugar determinations should always be made. I have found low blood calcium values where spasmophilia was not suspected.

I have never found a consistently low blood sugar to be responsible for true con-

vulsions.[8] I have one patient who has had three attacks of collapse and unconsciousness after a delayed breakfast or the morning after a vomited supper. On one occasion he had a fasting sugar value of 80 mg. at 9 a. m. following an attack at 7 a. m. He is usually revived promptly by the administration of sugar by mouth. Such cases of collapse or fainting are not rare, but I have never seen one develop true grand mal or recurring convulsions.

If the child is old enough, the Rosett deep breathing test may be made in an attempt to induce an attack.[9] The child is instructed to breathe as deeply as possible sixteen to eighteen times a minute with metronome regularity. After about five minutes the alkalosis produced will often precipitate a seizure. A petit mal is the easiest to elicit. A grand mal seizure cannot be induced unless the time in the cycle is about right. I have not found the pitressin test of value.[10]

Whenever possible the diagnosis of idiopathic epilepsy should be confirmed or established with an electroencephalogram. Every child with recurring convulsions is entitled to this harmless diagnostic procedure which may provide invaluable information not otherwise available. If there is still doubt about the diagnosis or if the child does not respond promptly to adequate treatment, a pneumoencephalogram should be made. While this operation is a major one and carries with it a certain hazard it may reveal information which cannot be obtained by any other means.[11] While a so-called normal pneumoencephalogram in a child with epilepsy does not positively exclude a cerebral lesion, it provides evidence that there is no extensive space-distorting lesion. Eley found that 90 per cent of epileptic children with normal pneumoencephalograms responded favorably to treatment with the ketogenic diet.[12]

Differential Diagnosis

The diagnosis of idiopathic epilepsy is made by exclusion. Before starting an indefinite course of treatment, it is most important that no diagnostic measure be omitted. The most common condition which might produce symptoms simulating grand mal epilepsy is the residue of cerebral birth injury. A carefully obtained history should reveal the difficult or protracted, or precipitate labor and a delayed physical and mental development. Also, the convulsions of birth injury residue do not recur periodically nor are they as characteristic or stereotyped. They usually have their onset in early infancy and diminish in frequency thereafter. The physical examination usually reveals some evidence of delay in development and often an assymetry of the reflexes.

Chronic encephalitis of any type may produce recurring grand mal convulsions. Here again the history will usually reveal the acute infection and the subsequent associated sequelae of this disease. This diagnosis should not be made without some confirmatory findings.

Tuberous sclerosis may simulate epilepsy, but the mental deterioration is much more rapid and the facial lesions are soon apparent.

Meningovascular cerebral syphilis and brain tumor may produce chronic convulsions, but they are not usually difficult to diagnose.

Pycnolepsy is probably a form of petit mal epilepsy.

Treatment

A diagnosis of idiopathic epilepsy is always a temporary one until the patient has been under observation for a long time. The patient must be followed closely and reexamined repeatedly for signs of localization or of an organic lesion. The longer epilepsy is allowed to continue untreated the more frequent and severe the convulsions become and the more resistant they are to treatment. Every convulsion leaves some residual, and eventually the recurring seizures leave permanent damage to the brain.

The treatment must be adjusted according to the manifestations of the disease, the frequency of the seizures, and the circumstances of the family. If possible the child should be placed in an entirely new environment, and all sources of irritation should be removed. A definite daily regimen should be instituted which will provide meals at regular hours and adequate exercise and rest.

TABLE 1

Preliminary Fast (10–14 days, in bed)

Fluid restriction 1,000 cc. (32 oz.)

Breakfast

200 cc. orange juice. (6½ oz.)
Bran wafers

Dinner

200 cc. broth (diabetic)
Bran wafers

Supper

200 cc. broth (diabetic)
Bran wafers
1,000 cc.—600 cc. = 400 cc. (13 oz.) water.
(to be divided between meals)

TABLE 2

GENERAL INSTRUCTIONS
(For ketogenic diet)

A gram scale is absolutely necessary.

Add to the diet nothing containing available carbohydrate, protein, or fat which is not included in the calculated diet chart.

Include one egg daily.

Use 300 Gms. cream daily if possible to insure a supply of calcium and phosphorus.

Use some raw fresh fruit and one cooked and one fresh vegetable daily to protect against mineral and vitamin deficiencies.

Bran wafers, diabetic bran breakfast food and "D. Zerta" may be used without allowance.

Broth may also be added but must be deducted from fluid allowance.

TABLE 3

SAMPLE KETOGENIC DIET
Five-Year Old Child

M. G. Peterman and Nell Clausen

Wt. 40 lbs. Ht. 42 inches
Carbo. 15 Prot. 18 Fat 132 Calories 1,320

FOOD	Breakfast	Dinner	Supper	Total Gms.	GRAMS Carbohydrate	GRAMS Protein	GRAMS Fat
Vegetables, 3%		30	70	100 100	3 3	1 1	0
Vegetables, 6%				100	6	1	0
Fruit, 12%	30			100 30	12 3	.7 .21	0
Vegetables and fruit, 15%				100	15	1	0
Vegetables and fruit, 18%				100	20	2	0
Butter	13	10	16	100 39	0	0	85 33
Bacon				100	0	16	50
Eggs	1			1 1	0	6 6	6 6
Meat, lean cooked		20		100 20	0	25 5	15 3
Cream, 20%				100	5	3	20
Cream, 30%—XX	100	100	100	100 300	3 9	2 6	30 90
Mayonnaise				100	0	0	85
Milk				100	5	3	4
Cereal (dry)				20	16	2	1
Total Grams					15	18	132
Cal. per Gm.					4	4	9

FOOD VALUE OF THE DIET

Total cal. of carbo. = 60
Total cal. of prot. = 72
Total cal. of fat = 1,188

Total Calories = 1,320

Fluid restriction 1,000 cc.

TABLE 4

KETOGENIC DIET

Five-Year Old Child

M. G. Peterman and Nell Clausen

SAMPLE MENU No. I

Breakfast

30 Gms. sliced orange
13 Gms. butter
1 egg—omelette
100 Gms. 30% cream
May have "cellu" bran breakfast food

Dinner

30 Gms. spinach
10 Gms. butter
20 Gms. scraped beef pattie
50 Gms. cream for drinking
50 Gms. cream—ice cream
Whip cream and flavor with ¼ tsp. vanilla
½ grain saccharin
May have bran wafers

Supper

Celery soup
50 Gms. cream
20 Gms. celery
10 Gms. butter
50 Gms. asparagus
6 Gms. butter
50 Gms. cream
May have "D. Zerta"
Fluids 300 Gms.
1,000 cc.—300 cc. = 700 cc. water may be allowed between meals.

A daily evacuation of the bowels must be arranged. There is often a history of constipation preceding the attacks. It is extremely important to correct the fatigue posture which is found in almost every epileptic child.

Petit mal seizures present the most serious problem in treatment. Parents and physicians are inclined to ignore or to minimize these mild or transitory attacks not realizing that they are more resistant to treatment and just as serious as are major convulsions. These patients usually develop grand mal attacks in the course of time. There is no drug which is effective in controlling petit mal. The only treatment which I have found effective is the ketogenic diet and fasting. Any refractive error in these patients must be corrected.

If grand mal or major seizures do not recur oftener than once a month, they may be treated symptomatically. Phenobarbital is practically a specific if used in adequate dosage and at the right time. It may even be used as a therapeutic diagnostic agent. If major convulsions do not respond to an adequate dosage of phenobarbital they are probably not due to epilepsy. Adequate dosage means about ¼ grain of phenobarbital two or three times a day for a child under two years of age, ½ grain at the same intervals from two to six years, 1 grain from six to ten years of age, and 1½ grains from ten to sixteen years of age. The drug should anticipate the attack by two hours. The dosage should be increased until the attacks are controlled unless undesirable side effects appear. When the attacks are under control the dosage must be maintained for at least one year. Then a slight reduction, one dose a day, is made each year. Phenobarbital must never be stopped abruptly in an epileptic.

Phenytoin sodium (Dilantin) has not been a satisfactory drug in my experience. The drug must be given in capsule form and is several times as expensive as phenobarbital. Almost all of the patients I have treated with phenytoin sodium have returned to phenobarbital by their own choice. The toxic reactions to phenytoin sodium which Merritt and Putnam reported in 15 per cent of their cases[13] have been disturbing.[14]

Drug therapy is purely symptomatic and should be utilized only when the basic cause cannot be effectively controlled. The most effective treatment for epilepsy is fasting or starvation. Since this is not practical for long periods of time, the ketogenic diet was evolved in an attempt to reproduce the ketosis-acidosis of fasting with, however, an adequate caloric intake to provide satisfactory nutrition. The ketogenic or high fat diet remains the most effective treatment of this disease and the only treatment which has any effect on petit mal.[15] The difficulties of this diet are no greater than are those of diabetic diets. The only limitation to be considered is the expense of fat foods, such as cream, butter and bacon. This treatment is the only one aimed at correcting the cause or counteracting its main effect.

The Ketogenic Diet

The details of preparation of the ketogenic diet have been adequately presented elsewhere.[16] It is preceded by a ten-day fast during which orange juice, diabetic broth, and bran wafers (no food value) are allowed.

TABLE 5

SAMPLE KETOGENIC DIET
Ten-Year Old Child

M. G. Peterman and Nell Clausen

Wt. 76 lbs. Ht. 54 inches
Carbo. 15 Prot. 34 Fat 177 Calories 1,789

FOOD	Break-fast	Dinner	Supper	Total Gms.	GRAMS Carbo-hydrate	Pro-tein	Fat
Vegetables, 3%		50	50	100 100	3 3	1 1	0
Vegetables, 6%				100	6	1	0
Fruit, 12%	30			100 30	10 3	.7 .21	0
Vegetables and fruit, 15%				100	15	1	0
Vegetables and fruit, 18%				100	18	2	0
Butter	20	20	20	100 60	0	0	85 51
Bacon			20	100 20	0	16 3.2	50 10
Eggs	1			1 1	0	6 6	6 6
Meat, lean cooked		70		100 70	0	25 17.6	15 10.2
Cream, 20%				100	5	3	20
Cream, 30%—XX	100	100	100	100 300	3 9	2 6	30 90
Mayonnaise			12	100 12	0	0	85 10.2
Milk				100	5	3	4
Total Grams					15	34	177
Cal. per Gm.					4	4	9

FOOD VALUE OF THE DIET

Total cal. of carbo. = 60
Total cal. of prot. = 136
Total cal.of fat = 1,593

Total Calories = 1,789
Fluid restriction 1,000 cc.

Two hundred cc. of juice, 400 cc. of broth, and 400 cc. water are allowed daily with as many bran wafers as desired (See Table 1). The patient is then given a diet consisting of a daily allowance of 15 Gm. carbohydrate, 1 Gm. of protein per kilogram (2.2 pounds) of body weight, with the remaining caloric requirement in fat. The daily allowance is 15 calories per pound (33 calories per kilogram) of body weight but need not exceed 2,000 calories. The requirements are summarized in Table 2, and calculations and sample menus (Nell Clausen) are submitted in Tables 3, 4, 5, 6. If the calculated diet does not control the convulsions, fat must be added, 5 Gm. to the daily allowance every week to the limit of tolerance if necessary. When the convulsions are under control the diet is maintained for at least three months. Then 10 Gm. of protein may be added to the daily allowance. After another month without convulsions 10 Gm. of carbohydrate are added to the daily allowance. The alternate additions of carbohydrate and protein are made monthly until the protein reaches 2 Gm. per kilogram of body weight. This amount usually satisfies the child and amply covers his requirements. After six months

TABLE 6

KETOGENIC DIET

Ten-Year Old Child

M. G. Peterman and Nell Clausen

SAMPLE MENU NO. I

Breakfast

30 Gms. fresh pineapple
20 Gms. butter
1 egg—scramble with cream and butter
100 Gms. 30% cream
May have "cellu" bran breakfast food

Dinner

50 Gms. broiled tomato
20 Gms. butter
70 Gms. steak with mushrooms (no available food value in mushrooms)
75 Gms. cream to drink
1 "D. Zerta" with 25 Gms. whipped cream

Supper

Vegetable soup
50 Gms. broth
10 Gms. celery
3 Gms. onion } 20 Gms. 3% veg.
4 Gms. carrot }
20 Gms. butter
20 Gms. raw cabbage with 12 Gms. mayonnaise
20 Gms. bacon
100 Gms. cream—cocoa
100 Gms. cream
¼ tsp. cocoa
½ gr. saccharin
Fluids—350 Gms.
1,000 cc.—350 = 650 cc. water may be allowed between meals

the daily fat allowance may be reduced by 10 Gm. every month. The menus should divide the food into three equal portions which should be given at well spaced intervals through the day, for instance at 7 a. m., 12 p. m., and 6 p. m. Only water should be given between meals.

If the epileptic seizures cannot be controlled by the diet alone after ketosis is maintained, phenobarbital may be added. Smaller doses will be required than if the patient is not on the high fat diet.

Conclusions

Idiopathic epilepsy is a distinct disease entity which is transmitted through heredity. The diagnosis is made by exclusion. The patient must be kept under observation and treatment for an indefinite period of time. The ketogenic diet is the most effective treatment for this disease and is not difficult to maintain. The epileptic should not be allowed to marry into a family with a history of epilepsy. It would be advisable to submit his prospective mate to an electroencephalogram before having progeny.

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"KEEP 'EM WORKING"

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"KEEP 'EM WORKING"

Treatment of Vaginitis in Children*

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VAGINITIS in children is a local infection which is very rarely associated with any complications such as salpingitis, peritonitis or pelvic abscess. It is more or less a self-limited disease, and spontaneous cure may result without treatment. There are three types of cases seen in a vaginitis clinic:

1. Nonspecific infection usually due to anaerobic Streptococci and B. coli.
2. Specific infection due to the gonococcus.
3. Endocrine disturbances in which infection does not play the predominant role, but excessive discharge is present.

Among children referred to our vaginitis clinic we find that approximately 75 per cent are not specific upon cultural checkup. Cohn, Steer and Adler[1] reported, "We are unable to gauge accurately the true prevalence of gonococcal vaginitis in children in New York City. We did ascertain, however, that an appreciable number of children who were reported as having specific vaginitis did not have a gonococcal infection. During the year, 759 children were examined for vaginitis because of discharge, suggestive smears, positive smears, or because they were contacts. Of these, 177 (23.3 per cent) were found to be positive." The report of the London County Council,[2] also based on cultures, showed similar results.

Gonorrheal vaginitis is understood to be an infection of the vagina caused by the gonococcus. This particular stage of a gonorrheal infection is rarely observed in the adult, as it seems to be only a transient phase in the development of this disease in the female. It certainly is more commonly seen in children and offers a very definite problem in therapeutics. As stated by Witherspoon:[3] "The treatment of gonorrheal vulvovaginitis in infants and young girls has always been an unsolved problem to the gynecologist, the pediatrician and the general practitioner. The various methods of therapy — vaginal instillations and irrigations, antiseptic applications to the cervix, the application of heat, the use of suppositories, change of bacterial flora and the administration of vaccines—have offered so little encouragement in the eradication of this condition that many physicians consider that no treatment at all is of equal value. Therefore, it was with great enthusiasm and with a warm reception that those who came in contact with this disease welcomed the rational hormonal therapy first advanced by Lewis[4] in 1933.

"Lewis'[4] method of therapy is based on logical clinical reasoning. Gonorrheal vulvovaginitis is usually limited to the prepuberal years. For reasons clearly explained by Schauffler and Kuhn[5] on the basis of microscopic study, the immature vaginal mucosa harbors the gonococcus in its crypts and offers a fertile means for its growth. With the onset of puberty and the conversion of the infantile vaginal mucosa into the mature, thickened stratified epithelium, the gonococcus no longer finds a fertile habitat, and the vulvovaginitis of childhood disappears. In fact, it is rare to observe gonorrheal vaginitis in a woman. The rationale of Lewis'[4] treatment was the conversion of the infantile vaginal mucosa into the mature type by administering the ovarian follicular hormone."

In an excellent historical review of therapy in gonorrhea, Wehrbein[6] states: "We may also mention its complications and so be assured that it is a problem worthy of great efforts. But the efforts must be less primitive; the disease is not known well enough. Its course without treatment cannot even be approximately stated with statistical figures; even with treatment we do not know yet if the average case may be expected to last two months or six months. Our pathological knowledge of the disease is still

* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

deficient. Where are the gonococci, how long do they last in near or remote foci, how are they slain or if this is too much what are their living conditions in vivo?

"Until some of these questions are solved it will be an accident if we find the means of shortening a gonococcus infection materially and it will be a miracle if we find a specific treatment."

Schauffler,[7, 8] and Schauffler and Kuhn[5] have given us an excellent description of the anatomy of the immature vagina and have indicated the reasons for the limitation of the infection to the vagina without the usual involvement of the accessory glands thereof. The lack of development in these glands does not predispose to their infection. They speak of the immature vagina as the "harbor of infection." They state:[5] "We know that, in the adult, the gonococcus is retained in the Skene's and Bartholin's and the cervical glands, and is frequently passed over from the cervical glands to the endosalpinx, while the vagina, except for a transient inflammatory reaction, is immune. We have shown that, on the other hand, in the infant and small child, the vagina is the point of election—the Skene's, Bartholin's, and endocervical glands are relatively noninfectable, and there is immunity of the endosalpinx secondary to that of the endocervix.

"It is not sufficiently clearly understood, even by those who have made something of a study of gonorrheal infections in infants, that the vaginal cervix is the seat of deep pleats and folds similar in all respects to those noted throughout the remainder of the vaginal wall, thus, the vaginal cervix is not exempt from an infection which involves the entire vaginal wall. This fact was early noted by Hess in a series of postmortem examinations. Unfortunately, Hess' observation has been misconstrued. In his own report Hess carefully differentiates between the vaginal cervix and the endocervix. He reports infections of the vaginal cervix only. He has been broadly quoted to the effect that at postmortem he has demonstrated 'cervical infections,' with the inference that endocervical infection has been described. This inference is not justified. The use of the term 'cervico-vaginitis' to describe such infection, while it is perhaps more minutely descriptive, we believe is misleading in that it suggests a frequent involvement of the endocervix as an accompaniment of vaginal infections. Endocervical infection as an integral part of the pathology occurs only in individuals who have reached a stage of advanced development of the cervical glands. It is perhaps an occasional transient accompaniment of severe acute infection of the immature vagina.

"The use of the descriptive term 'vulvovaginitis' is distinctly a misnomer. The vulvar irritation in these cases is completely secondary, and due to factors similar to those which cause external irritation in pyelitis, diarrhea, etc."

Cohn, Steer and Adler[1] concluded: "Cultures were found to be superior to smears in the diagnosis and determination of cure in gonococcal vaginitis, especially in subacute, chronic and carrier states, during estrogenic treatment, and in rectal infections . . . When the culture was used for diagnosis, gonococcal vaginitis was found to be less prevalent than heretofore believed."

Mukherjee[9] reported that, out of 1,138 cases of gonorrhea treated at his clinic, 125 occurred in female children, 11 per cent. Serious sequelae seldom follow an attack of vulvovaginitis. Cures were obtained with local treatment only in 62.5 per cent; progynon only in 44 per cent; combined therapy in 84 per cent. Relapses occurred in 12 to 32 per cent of the patients.

Diagnosis

In our own study of vaginitis[10] in the Washington University Clinics, we have used Gram's stain for all specimens and have checked our findings by the culture method, using Gradwohl's media. We have grouped the cases into specific and nonspecific vaginitis and have thereby reduced the total number of patients being treated for gonorrheal vaginitis to a very small group. The period of attendance for the nonspecific group has been greatly reduced. A positive diagnosis is made on demonstration of typical biscuit-shaped intracellular gram-negative Diplo-

cocci on direct smear and culture of the organisms on the special hormone-agar media.

The use of methylene blue stain for the diagnosis of vaginitis is frequently misleading since intracellular Diplococci may be found which are almost identical with the gonococcus. These organisms are found to be gram-positive when checked with Gram's stain and upon culture are anaerobic streptococci. I have consistently noted that the anaerobic Streptococcus is a diplostreptococcus (a chain of pairs of cocci) and may readily be broken up into pairs. Final determination of the organisms present should be on the basis of cultural results.

Schauffler,[11] in a recent article, describes in detail the technic of abdominal and pelvic examination in female infants and children. Differences in the anatomy of the infant and adult pelves are noted.

Complications

Complications were rarely seen associated with vaginitis in children. However, we observed that the condition was apt to become chronic or at least recurrences were frequent. Many such patients would be regular attendants at clinics for several months, or even years, and would be kept away from school during such extended periods. Others would return for treatment repeatedly on hospital services and would spend a considerable portion of a year or two in the hospital usually at public expense. As the result of the treatment plan which we have followed for several years, patients are hospitalized for from four to six weeks and relapses have been very infrequent. All of the chronic cases have been discharged cured. There is an apparent drop in incidence of late, and this may be due to the removal of adult sources of infection by the widespread use of the sulfanilamide group of drugs.

Physiology of the Vagina

The physiology of the vagina is such that in the newborn infant infection is not likely. However, in two to six weeks changes have occurred which render the vagina more susceptible to infection. These changes are illustrated in a chart by Karnaky[12]. Should we not attempt to maintain the physiology of the vagina as nearly normal as possible?

In Mukherjee's[9] series the youngest patient with gonorrheal infection was five months old. Winkoop and Boggs,[13] in a series of 500 infants examined during the first two weeks, failed to detect a single case of gonorrheal vulvovaginitis. The youngest patient in Nora Wattie's[14] series was five weeks old. The youngest patient with gonococcus vaginitis in our service was four weeks old. A patient was admitted recently with the diagnosis of gonorrheal ophthalmia and vaginitis. The ophthalmia proved to be specific, but, upon culture, the vaginitis was due to B. proteus, even though clinically it simulated a specific infection. I doubted the diagnosis because the patient was but ten days old.

Treatment

Vaccines of many different types have been used with very little consistent relief being obtained in most cases.

Innumerable antiseptics have been used for many years, the favorites being members of the silver group. In 1920, Gellhorn[15] proposed the use of 1 or 2 per cent silver nitrate in an ointment base. The duration of the disease was not greatly shortened by this treatment, and at times complete failures resulted. Potassium permanganate has been used extensively in varying concentrations and seems to be of value, provided that the solution is 1:2,000 or stronger. A solution of 1:1,000 in my experience has given excellent results without any harmful reaction in the tissues.

In 1928, Edgar Allen[16] demonstrated the transformation that could be effected in the vagina of the immature monkey by the administration of ovarian hormone. After the injection of 1,005 rat units of ovarian hormone over a period of twenty-one days, the vagina of the monkey exhibited an epithelium averaging thirty layers in thickness and differentiated into two zones. The vaginal epithelium of the control monkey, on the other hand, remained four to eight layers in thickness. Smears showed a proportional increase of partly or completely cornified epithelial cells. Associated with the vaginal changes there was some development of the

cervical glands and an invasion of their lumina by many polymorphonuclear leukocytes. The endometrium was "built up" at most to a midinterval phase. Involution of the structures affected by theelin occurred in a few weeks subsequent to the last injection of the hormone.

Lewis[4] asked: "Could a similar result be obtained in a child? A gonococcal infection in the vagina subsides when the delicate thin layered epithelium lining the vagina is converted into the thicker structure of the adult. Primary infection in the adult vagina is either extremely shortlived or nonexistent."

With these ideas in mind Lewis[4] began the study of the effect of theelin on gonorrheal vaginitis in children and in 1933 reported his results in a series of 8 cases. Subsequent to this several reports have been made showing the good results obtained by the administration of hormone therapy in varying doses by different routes.

Witherspoon[3] reported that ten children with gonorrheal vulvovaginitis have been unsuccessfully treated by the administration of the ovarian follicular hormone, amniotin. The criteria of lack of success are the persistence of the vaginal discharge and the presence of gram-negative intracellular Diplococci in the vaginal smears. Several disadvantages of this method of therapy are pointed out, such as the harmful effect on the immature ovary by the hormonal action on it, cervical infection in addition to vaginitis as a focus of continuing the disease, the unpleasant features of the daily hypodermic injections, the occasional unfortunate secondary sexual changes, such as enlargement of the breasts, vulval hyperemia and hypertrophy, and lastly the high cost of this method of therapy.

It is very likely that the observations of Witherspoon[3] are the result of inadequate dosage or because of the manner in which the hormone was administered.

Allen and Diddle[17] have checked the ovarian follicular hormone effects on the ovaries in an experimental way, using immature monkeys. There was a definite reddening and swelling of the sexual skin, and an increase in the size of the uterus was noted. The ovaries were studied immediately after the period of injection and also after a thirty-day recovery period. They concluded, as far as they could tell histologically, that there seemed to be little damage to the ovaries and that the reaction was temporary. They state, "The therapeutic use of comparable doses of this hormone in children may be prescribed without fear of harmful results upon ovaries."

TeLinde and Brawner[18] conclude:

"1. Amniotin administered orally or hypodermically in ethylene glycol solution is of no value in the treatment of gonococcal vaginitis. We have been unable to demonstrate any effect of the hormone on the vaginal mucosa or breasts.

"2. Amniotin in oil has proved effective both in the production of maturation of the vaginal mucosa and in its therapeutic action in gonococcal vaginitis in 72 per cent of the cases. In most of the patients receiving prolonged treatment breast hypertrophy was noted.

"3. Amniotin in suppository form has been proved to be effective in the production of mature vaginal epithelium and in its therapeutic effect in gonococcal vaginitis in all the cases in which we have used it. This group included some cases which had been resistant to the hormone when administered hypodermically in oil.

"4. The epithelial change produced by the hormone, whether administered hypodermially or in suppositories, is transient, and there is no clinical or experimental evidence to show that its administration is harmful in dosage necessary to cure this disease.

"5. So far as our experience has gone we have concluded that amniotin administered in suppository form is superior to any other known method of treating gonococcal vaginitis."

Lewis and Adler[19] found that the estrogenic substance in ethylene glycol given hypodermically was relatively effective when used in large doses: 2,400 international units daily. Eight hundred international units daily proved disappointing. Estrogenic vaginal suppositories (originally 600 international units and later 1,000) proved very effective. They also noted that the administration of estrogenic substance changes the reaction of the vaginal secretions from neu-

tral or alkaline to acid, and they believe this to be a major factor in elimination of the gonococcal infection. The acidity of the vaginal secretions is easily measured and provides a sure guide by which one can determine whether or not dosage is adequate. They encountered no ill effects and consider this type of therapy harmless and also most effective.

Three-Year Study

In 1934, we[10] reported a three-year study of the treatment of gonorrheal vaginitis by the insertion of vaginal suppositories containing 0.16 Gm. pyridium in a base of boroglyceride of gelatin at bed time. This is followed by a cleansing douche of 1:1,500 potassium permanganate (5 grains to 1 pint of water). It was possible to obtain negative smears and cultures in definite cases of gonorrheal vaginitis following the treatment by the suppositories alone. We have now studied about 100 cases of gonorrheal vaginitis treated satisfactorily by this method and feel that it is definitely effective, simple in application and has no harmful side actions. The average course of treatment extended over a period of from four to eight weeks, depending upon the cooperation of the patient in carrying out the treatment. Treatment should probably be continued for ten days to two weeks after negative smears are obtained. By means of this type of treatment any complicating urethral infection is taken care of by the fact that pyridium is absorbed from the vagina and is excreted through the urinary tract, bathing the urethra with a definitely antiseptic solution. Do not catheterize such patients. The folds, as noted in the vaginal portion of the cervix by Schauffler,[7] are also treated by this method of application, and it seems likely that reinfection of our cases has been less frequent than in other series because of these additional actions. The pH of the pyridium suppositories is approximately 4.0, and it is possible that this chemical reaction in the vagina enhances the action of the pyridium suppositories. The importance of the pH of the vagina will be stressed in the consideration of other methods of therapy.

Abrams[20] reports his impressions of the various types of therapy and finds: "A small percentage of the patients in the past who have had persistent positive smears have shown involvement of the cervical glands. I feel that in a large series of cases it is possible this will occur even with the use of estrogenic substance and when smears do not become negative the cervix should be investigated by means of a small electrically lighted endoscope."

Crossen[21] reported on the treatment of gonorrheal vaginitis by diathermy and obtained consistently negative smears in the acute series after twenty-nine weeks. The average length of treatment required to give consistently negative smears in the chronic cases was a little over four weeks. The difficulties in applying this method of treatment to young children make it undesirable from a practical standpoint.

Karnaky[12] has studied the treatment of vaginitis in general in regard to: (1) the bacterial flora of the vagina, (2) the glycogen content of the vaginal mucous membrane, (3) the number of Döderlein bacilli present, (4) pathologic conditions of the vagina and (5) the hydrogen ion concentration of the vaginal secretions. He finds that there is a definite relationship between these five factors upon which depend the life and growth of vaginial micro-organisms. As a result of his study, he recommends a tablet containing an adequate amount of glucose in a form that can be utilized to supply the epithelial cells and nourish the Döderlein bacillus. Sufficient boric acid is added to establish a pH of 4.0 and produce a mild astringent action thus diminishing the amount of the discharge. Also incorporated in the formula is a quantity of diodoquin, a new quinoline ring giving it an iodine content of 63 per cent (5–7 diiodo–8–hydroxyquinoline). It is an insoluble and nontoxic compound, and experiments which he has conducted prove its effectiveness in destroying organisms of the protozoan type. His treatment has also proved satisfactory in the treatment of gonorrheal vaginitis. The name of the preparation used is "Floraquin."

The importance of the pH of the vaginal secretions in relation to the cure of gonorrheal vaginitis will now be considered. Lewis and Adler[19] stress this factor as the means of demonstrating adequate estrogenic therapy. They state: "It is of course of the utmost importance to determine the presence or absence of the vaginal response to estrogenic substance in all cases, as without this tissue change no benefit can be expected. This was formerly done by securing minute biopsies and examining sections with the aid of the microscope. This method is time consuming and expensive. Vaginal smears showing extraordinary desquamation of epithelial cells are evidence that the estrogenic reaction has occurred. The inexperienced observer will, however, often be mislead, particularly if the exfoliation is not great. The gross appearance of the vaginal mucosa and introitus is frequently helpful.

Another Practical Test

"We wish now to stress the value of another simple practical test of the estral response which can be carried out easily in a few minutes. Long ago Döderlein[22] called attention to the presence of the bacillus named for him and considered its acid-forming properties as responsible for the acid reaction of the secretions of the adult female vagina. Zweifel[23] later showed that it was the destruction of the superficial glycogen containing cells of the vaginal mucosa that produces much of the acidity. In the thin vaginal mucosa of the child but little glycogen is contained. On the other hand, the superficial cells of the adult vagina and, of more importance to us, of the vagina of the child adequately treated with estrogenic substance are loaded with glycogen. These as a result of bacterial or enzymatic action produce a markedly acid reaction as they break down. Socken[24], Cruickshank[25] and others have described the histologic changes that occur during puberty and ordinarily before the occurrence of the first menstrual period. They have also pointed out the dramatic and abrupt change to acidity in the reaction of the vaginal secretion which occurs at this time and that this in turn is accompanied by an equally rapid transformation of the vaginal flora. In vitro the gonococcus grows best in a faintly alkaline medium (pH 7.2 to 7.6). If this is rendered acid very gradually over a period of days or weeks these organisms will rarely adapt themselves to a medium as acid as pH 6 to 6.2. Usually the culture dies before this point is reached. Tests that we have carried out to determine the pH of the vaginal secretions of children in our series before treatment have given pH values between 6.8 and 7.4. With the appearance of the estrogenic reaction of the vaginal mucosa (checked by biopsy and microscopic section), the vaginal secretions became acid (pH 4.5 to 6.2), nearly always giving readings below 6. . . . Nearly every case in which the pH of the vaginal secretions dropped to below 6 recovered from the gonococcic infection. Consequently we believe this acid change of the vaginal secretion is the important curative factor produced by administration of estrogenic substance in gonococcic vaginitis of children."

Krumm[26] finds variations in the glycogen content of the vaginal mucosa as shown by the Schiller–Gram test to be a relative index to the quantitative amount of ovarian hormone present in the body. Therefore, this test can be used in checking the efficacy of estrogenic substances which have been given by various methods in the hope of obtaining a therapeutic response.

Adair and Hesseltine[27] have investigated the histopathology of vaginitis and the biochemical approach to therapy thereof. A mixture of lactose (95 per cent) and citric acid (5 per cent) was used with the result that definite changes occurred in the epithelial layers of the vaginal wall. The histologic picture is restored nearly to normal including an increase in the number of glycogen granules in the epithelial cells. The use of lactose instead of glucose as the sugar in such treatment is emphasized in order that the development of mycosis may be avoided.

Oberst and Plass[28] studied the hydrogen ion concentration of human vaginal discharge by means of a quinhydrone microelectrode and found it to be normally pH 4 to 4.5 during the intermenstrual period. They also

noted the corresponding changes in the vaginal flora that occur with the changes in reaction.

In recent years we have substituted various members of the sulfanilamide group of drugs for pyridium in making our suppositories but as yet without satisfactory results. The administration of these drugs by mouth is not without hazard. Since gonorrheal vaginitis is essentially a local infection, I am opposed to treating it by the systemic route and prefer to treat it locally.

In a patient diagnosed as having gonorrheal vaginitis the first type of therapy used was sulfanilamide without results locally. However, the baby became so anemic as the result of this treatment that several transfusions were necessary to restore it to general well-being. Next hormonal therapy was applied, and the disease was not cured, but the right Bartholin gland developed sufficiently to allow infection to occur—Bartholin abscess. I then suggested that we return to our routine treatment with pyridium suppositories, and within eight weeks the baby was discharged cured. The sad part of this story was that this patient had spent the greater part of its first year of life in the hospital.

Routine Treatment

At present our routine treatment consists of lactic acid douches (1:2,000) twice daily in amounts of from 500 to 1,000 cc., depending upon the age of the patient and amount of discharge. The douche may be given via Dakin tubing, catheter or enema tip.

Rx Acid Lactic (85%) U.S.P. -------- 30 | 0
Aqua dist. q.s.ad. ---------- 240 | 0
M. Sig.: One teaspoonful in one quart of warm water as douches.

At bed time a suppository containing 0.16 Gm. of pyridium is inserted into the vagina. This treatment is given at bed time so that with the child at rest the pyridium, as the suppository melts, comes in contact with the entire vaginal mucos membrane. The drug is absorbed from the vagina and excreted by the urinary tract.

The pyridium is incorporated in a base of boroglyceride of gelatin. The suppositories are of such size and shape that they readily slip into the vagina with gentle pressure by distending the hymenal ring slightly and do not return because the size of the base of the cone is sufficient to stop at the hymen.

In patients with nonspecific vaginitis, lactic acid irrigation alone is usually effective in restoring a normal vaginal physiology. In others with lowered basal metabolic rate, thyroid medication will be helpful. Douches with aluminum acetate, one teaspoonful in one quart of water, may be given temporarily for its antiseptic and astringent effect. Nizin (Burroughs Wellcome & Co.) has been effective as a douche (use one teaspoonful in one quart of water). Antiseptic douches should not be continued longer than two weeks, or they may interfere with the normal flora of the vagina. After these douches are discontinued, an occasional irrigation with lactic acid douches will maintain normal reaction in the vagina.

Therefore, we see that a number of biochemical, endocrinologic and histopathologic factors must be taken into account if our therapy of gonorrheal vaginitis is to be rational.

Conclusions

1. Vaccines and antiseptics have been of little aid in the treatment of vaginitis.

2. Hormone therapy is successful if the estrogenic substance is given by the proper route, as suppositories, in adequate dosage. There is apparently an appreciable number of recurrences, about 10 per cent. May these not be due: (a) to the development of cervical and endometrial glands in response to the estrogenic substance (Allen[16]), which would predispose to the spread of the infection to areas which have not been involved in the original disease, and upon the withdrawal of treatment might these areas act as foci and reinfect the vagina as it returns to its original immature state; (b) to the lack of treatment of certain original foci (e.g., urethritis)? Complications may result from action on the glands.

3. We still may be unaware of certain byeffects of hormonal treatment which have not been demonstrated as yet, but nevertheless may be present and cause possible com-

plications in certain patients at a later period in their development.

4. Pyridium therapy has been generally satisfactory in both specific and nonspecific vaginitis. It is (a) quite economical, (b) prompt in production of results, (c) easy of application, and (d) general in action as well as local, which may account for the lesser incidence of recurrences.

5. Sulfanilamide and related drugs may be of value but are not without undesirable by-effects. Results of such therapy are as yet not uniform. Recent results of treatment with sulfathiazole by mouth appear to be satisfactory in about 75 per cent of cases.

6. The role of maintaining a normal physiologic state in the vagina seems of the utmost importance, and this is quite readily acomplished by the use of lactic acid douches.

7. Progress in the treatment of gonorrheal vaginitis will be made if we continue to rationalize our therapy along biochemical and endocrinologic lines. Perhaps the best results can be obtained in certain cases by the use of various combinations of the methods discussed.

8. Since vaginitis is a localized disease, why not treat it locally?

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KEEP 'EM WORKING

Comments on Treatment

Editor—A. J. QUICK, M. D., Marquette University, Milwaukee

Vitamins in Health and in Disease

In the enthusiastic acceptance of new advances in medicine and especially in their commercial exploitation, there is a constant danger that basic facts of physiology are apt to be ignored. One such fundamental concept is that food provides two main essentials for body economy: (1) material for energy and (2) substances or chemical compounds needed for structure. By the latter term is meant not only the actual physical and visible tissues of the body, but also the enzymatic mechanisms. Therefore, a satisfactory diet must contain sufficient caloric value to meet the daily energy requirements and also a sundry assortment of chemical compounds needed by the body which it cannot synthesize. Among these are the essential amino acids, various minerals and the vitamins.

It behooves one to recognize that there is nothing mysterious or magic about vitamins. They are compounds which the body needs for certain specific purposes but cannot itself produce or synthesize. There is no essential difference, for instance, between the amino acids, histidine and phenylalanine on the one hand; and the vitamins, ascorbic acid and riboflavin on the other hand. All four compounds are indispensable for normal physiologic function, and none of these can be made by the organism, but must be obtained from the food. Therefore, it is equally as important to have an adequate amount of the indispensable amino acids as to have the required quantity of vitamins.

To secure the proper intake of amino acids, one does not attempt to ingest pure amino acids but selects a diet which includes proteins containing the various amino acids. Likewise, in safeguarding against vitamin deficiency, the logical course is to select natural foods that contain sufficient amounts of the various vitamins to meet the normal demands. The practice of depending on vitamins "from a bottle" or "in capsules" should not be sanctioned by physicians. In the first place, vitamins in food are cheap while pure or concentrated preparations are relatively expensive; and in the second place, the ingestion of excessive amounts in concentrated form is apt to be wasteful. Furthermore, it is very probable that many vitamins have not yet been isolated or even recognized, and the only sure way of getting these is in natural foods. Fortifying staple articles of food with vitamins such as the addition of B_1 to flour and D to milk by irradiation is highly important, since the average diet is low in these particular vitamins.

Since the general public is constantly bombarded with vitamin advertisements, it should be emphasized that an average individual can secure all of his vitamin requirements from his food and that there is no justification under normal circumstances to take extra vitamins in pure or concentrated form. Few of the vitamins are stored in any appreciable quantity, and any excess is usually either destroyed or excreted. Therefore, it is extremely doubtful whether amounts greatly in excess of the body's requirement are of any value. A well fed baseball team will win even without taking a special brand of vitamins.

The vitamins are foods not drugs. They are not stimulants. They do not cure that "tired feeling" unless the patient actually suffers from avitaminosis. There is no convincing evidence that they increase resistance against infection in an individual receiving an adequate diet. The effect of vitamins on immunity is still purely speculative.

In disease, the wise use of concentrated vitamins is often of great value. Frequently, the diet is poorly balanced or so limited that the intake of vitamins is inadequate. In gastro-intestinal disturbances the absorption may be so impaired that only a small fraction of the ingested vitamins is obtained. In fever and wasting diseases, the destruction and consumption of vitamins such as ascorbic acid may quickly exceed the intake. Often lack of appetite leads to a vitamin B_1 deficiency which in turn causes further anorexia, thus initiating a vicious circle. Only a physician is qualified to decide when and what vitamins to use in disease, and assuredly no one who professes to practice scientific medicine will resort to haphazard "shotgun" type of vitamin therapy. A. J. Q.

The Nation at War

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Narcotic Registrations From Physicians in Service

THE office of the Society has had so many inquiries from physicians in regard to the necessity of applying for narcotic registrations when the physician is contemplating entering service that an opinion was asked of Mr. Frank J. Kuhl, collector of the Internal Revenue Service, Treasury Department, Milwaukee. The following letter, we feel, will clarify the situation.

September 25, 1942

C. H. Crownhart, Secretary
State Medical Society of Wisconsin
Madison, Wisconsin
Dear Sir:

Reference is made to your letter of September 23, 1942 wherein you inquire concerning applications for narcotic registrations from physicians contemplating entering the service or who have already entered the armed forces.

If a physician making application for a narcotic registration in this district can furnish an office address which may be either his residence, or a bona fide office address, his application will be accepted. The fact that he is entering the service or is already in the armed forces does not give this office the privilege of refusing the application inasmuch as he has the right as a physician licensed under the State laws to carry a narcotic registration. However, in many cases, these physicians feel they must have a narcotic registration as a matter of form, and when they are informed that their duties with the armed forces do not require a narcotic registration for the reason that their status as a medical officer of the service permits them to prescribe and dispense narcotics in line with their official duties, they do not then, in most cases, present their application.

This office is unable to account for the reason why a physician recently receiving a certificate feels it necessary to have a narcotic registration when he is already commissioned in the armed forces or will very shortly receive a call. However, as stated above, this office has no option in the matter but to accept an application if tendered, and while the completion of the registration is contingent upon approval of your office, your opinion must rule in the matter of extending this approval.

The tax to cover a narcotic registration for a physician, osteopath, dentist and veterinarian is $1.00 per annum or fraction thereof. This fee applies to both new registrants and renewals.

Physicians who heretofore have carried narcotic registrations and who have entered the service have been advised that they may continue their registration if they see fit to do so. If renewal is requested, they must furnish an office address for this district. In case they wish to discontinue their registration, they are informed that narcotics in their possession must be disposed of and unused opium order forms returned to this office.

In case the questions in your letter have not been fully answered, do not hesitate to again write this office.

Respectfully,
(Signed) Frank J. Kuhl
Collector

Emergency Medical Service Sound Film Strip Available

THE Medical Division of the Office of Civilian Defense has prepared and made available for distribution a film strip depicting the operation of the Emergency Medical Service Corps. The film may be used as a sound film strip employing a twelve inch record. The film strip is advanced with each sound of a bell that is heard in the recording.

The film is composed of 100 still pictures showing the operation of the control center, the air raid wardens, and other divisions of the Civilian Defense organization. Emphasis is placed on the integration of the several different divisions of Civilian Defense, how each is different from the other, and how the activities of the several branches are correlated in the event of a disaster. The film depicts a simulated air raid from the moment the enemy planes are spotted. The air raid warning is heard, bombs fall, and the Emergency Medical Service springs into action.

This film strip is available to the members of the State Medical Society of Wisconsin. Upon request the Society will furnish the film, the manuscript and the projector to members for showing to their local Medical Corps or for showing to county councils of defense or other interested groups.

It will be necessary for members who wish to use this equipment to make prior arrangements for a portable sound phonograph. These have been widely distributed by automobile manufacturers to local automobile sales agencies, refrigerator sales agencies and farm implement dealers. Physicians may obtain them from these local agencies.

Also supplied with each film strip and record is a script of the material recorded for each picture on the strip. A portion of the strip is reproduced at the left of this story, and below are reproduced the comments which are made by the narrator for each of the pictures shown in the accompanying cut. The top picture is frame No. 55 of the strip with subsequent frames Nos. 56 to 64 inclusive.

Frame No. 54. *Narrator:* In communities where air raids occur frequently, or in areas where there are no hospitals, or where resident staffs are too small, it is necessary to organize other physicians and nurses in the community into Reserve Emergency Medical Field Units.

Frame No. 55. A Casualty Station is a permanent predetermined site such as the clinic of a hospital, health department or voluntary agency, a school basement or any other place which provides shelter, accessibility and protection. It is the place of assembly.

Frame No. 56. . . . for squads of an Emergency Medical Field Unit and for the Stretcher Teams. Each station requires at least four to six Stretcher Teams organized in the neighborhood. From the Casualty Station medical teams and stretcher teams are dispatched to the scene of the disaster.

Frame No. 57. Each Casualty Station has telephone communication with the Control Center and reports the activities of transportation groups, the number of casualties and other information.

Frame No. 58. The *equipment* at the Casualty Stations constitutes a source of supply for the medical teams and also includes bulky articles such as traction splints which cannot be conveniently included in the first-aid kits.

Frame No. 59. Blood plasma and other biological products such as tetanus anti-toxin or toxoid may be obtained by the Casualty Stations from the parent hospital as needed.

Frame No. 60. *Narrator:* The work at the Casualty Station is limited to first-aid procedures. The station serves as a first-aid post if located *close* to the scene of the bombing incident. Otherwise a Medical Team is *sent from the Casualty Station.*

Frame No. 61. . . . to set up a *temporary* first-aid post near the scene of the incident.

Frame No. 62. A Medical Supply Depot should be located *at* or *near* the Casualty Station and in times of emergency should be prepared to furnish the station with as many as twenty stretchers, fifty collapsible cots and 100 blankets per 10,000 population in the area.

Frame No. 63. Also at or near the Casualty Station may be located a canteen and the reclothing and rehousing services of the Red Cross or the municipal welfare department.

Frame No. 64. Finally, decontamination stations may be located near Casualty Stations or at the hospitals, for treatment of both the injured and the uninjured who have been exposed to persistent war gases. This must be done before casualties are transferred to a hospital.

The Government Urgently Needs Quinine

The Journal of the American Medical Association, October 3, 1942, published an article appealing to the pharmacists of the nation to turn in their supplies of quinine to the government. Undoubtedly the doctors of the nation also have supplies of quinine which could be turned in. Let the members of the State Medical Society put this item on their list of "musts" for contribution to the war effort. The article published in *The Journal of the American Medical Association* was as follows:

The War Production Board has issued a call to pharmacists throughout the nation requesting them to turn in their supplies of quinine, regardless of age, quantity or nature. All salts of quinine, quinidine, cinchonine and conchonidine are wanted. Since the supply of these medicines has been cut off and the quota for each man in our armed forces is 4 ounces a year, the need is urgent.

Domestic use of quinine and similar chemicals, except for malaria, has been curtailed, making it possible for pharmacists to return unopened packages to their wholesalers for credit, and their opened packages to recognized clearing houses for assay and transfer to military medical supply stores.

The Philadelphia College of Pharmacy and Science has volunteered to act as an assaying depot for any opened packages of quinine compounds that are contributed to the war effort by patriotic pharmacists. Each package received will be tested for identity and then placed in a common container with other quantities of that particular salt. Then each mass of accumulated chemicals will be assayed for strength, certified, and sent to the Defense Supplies Corporation, which will direct the shipments to proper medical authorities. The less common salts of quinine, such as the valerate and the acetate, will first be processed to quinine sulfate or hydrochloride.

Clean, presentable quantities of quinine salts, quinidine, cinchonine and conchonidine are wanted. Pills and tablets are not desired at this time. Pharmacists in the Southern states, where malaria may occur, should retain enough quinine sulfate or hydrochloride to meet their demands. All other pharmacists should ship their loose stocks immediately, by parcel post, to the Philadelphia College of Pharmacy and Science, Philadelphia. Unopened packages should be returned immediately to wholesalers, who will forward them to proper authorities and reimburse the sender.

Do it now! The need is great! Let there be no more Corregidors or Bataans for lack of quinine to fight diseases to which our soldiers and sailors are exposed.

The War Production Board has formally authorized the college to offer this service. All packages should be addressed to Quinine Pool, Philadelphia College of Pharmacy and Science, 43d Street, Woodland and Kingsessing avenues, Philadelphia.

The Physicians' Reference Book of Emergency Medical Service

Published by E. R. Squibb & Sons

The Physicians' Reference Book of Emergency Medical Service provides excerpts from the literature, particularly the British medical literature, but also in part from American sources, describing casualties which may be expected from aerial warfare, the experience which has been had in handling them, together with the latest information on treatment of shock and burns.

It deals with the manner in which ordinary civilian accident practice must be modified in order to deal with crush, blast, bomb and other injuries as encountered in air raids. It contains a full discussion of war gas injuries and their prevention and treatment. The book is provided with a complete author and subject index.

The volume is available from the State Medical Society of Wisconsin to interested physicians on request.

KEEP 'EM WORKING

Mark November 17 on Your Calendar as a "Red-Letter" Day

KEEP 'EM WORKING

Why Censorship?

MR. BYRON PRICE, director of Censorship, who recently appeared before the Southern Newspaper Publishers Association, stated that "In censorship, as in all things, there is, somewhere, a road of common sense. We must find it." In his opinion, the newspapers of the country have done a good job of striking a balance in publishing many interesting columns of war news and yet taking infinite pains to keep certain other information from the enemy. On the other hand, Mr. Price feels that the newspapers have done a poor job of informing the public why some information has to be withheld.

"What is the basic consideration behind Censorship? It is simply this: That none of us shall provide the enemy, by design or inadvertence, with information which will help him to kill Americans. Just that, and nothing else. . . . Sometimes the enemy will have the information, but very often he will not; and I know of no good reason why, in a matter of life and death, we should give the enemy the benefit of the doubt. . . . The enemy may know many things, but there is much more he would like to know. Why put at his disposal, anytime, anywhere, the expert fact-finding machinery built up by the American press through years of patient struggle?

". . . Why are you asked not to disclose in what regiment John Doughboy is serving in Australia? Certainly the enemy knows that there are American troops in Australia and it probably would not add greatly to his knowledge to know that John Doughboy was among them. But if you tell him what regiments are there, he will know the total strength of General MacArthur's forces, and also can tabulate in detail what arms and equipment they are likely to have with them, and what special training they have had.

"In all of these things, let's be sensible. The enemy is not superhuman. He can be deceived and he can be frustrated. It is not on the side of common sense to assume otherwise, or to give him the benefit of the doubt.

"Every American should resolve his doubts, instead, in favor of his own country, in favor of safeguarding that country and preserving it against failure or mischance. . . . There isn't any story in the world that is good enough to justify risking the life of a single American soldier."

First-Aid and Home Nursing Films

GREAT demand is made upon members of the Society to assist in instruction on first aid, home nursing and similar health topics in connection with civilian defense. To assist members of the Society in this patriotic effort, a study has been made of the motion picture teaching aids which are available through the Bureau of Visual Instruction of the University of Wisconsin. The following films are available at a nominal rental charge as shown opposite the description of each film.

Home Nursing (Sound)

"Demonstrates factors involved in the hygienic care of a home patient after instruction from a visiting nurse. Bathing and moving the patient in bed, arranging the bed, and generally making the patient comfortable are shown. Taking of temperature, pulse and respiration rates and their recording, medications, visits by the doctor, and helping the patient gradually to regain strength conclude the presentation." (Erpi)

1 Reel. $1.25 Service Charge (One day)

First Aid (Wounds and Fractures) (Sound)

Produced in collaboration with the American Red Cross. "Focuses attention on the need for first-aid knowledge and describes proper procedures in caring for an injured person from the time of injury until medical aid arrives. Demonstrates methods of applying pressure at different parts of the body for stopping arterial bleeding. Shows technic of immobilizing fractured bones by means of splints and braces. Animated drawings clarify anatomical and physiological features." (Erpi)

1 Reel. $1.25 Service Charge (One day)

First Aid (Control of Bleeding) (Silent)

"Shows, with actual photography and animated diagrams, accepted methods of control of arterial and venous hemorrhage in various areas of the body." (Eastman)

1 Reel. $0.75 Service Charge (One day)

(Editor's Note: This is an excellent film employing both live subjects and schematic diagrams showing how bleeding can be controlled by manual pressure and tourniquet.)

First Aid (Care of Minor Wounds) (Silent)

"Stresses the importance of immediate care for even the slightest wound. Demonstrates in detail the proper method of applying sterile dressings." (Eastman)

¼ Reel. $0.50 Service Charge (One day)

(Editor's Note: This film outlines the means which should be employed in the care of minor wounds in the home. Incorporated in the film is a series of diagrams showing how infections spread through the lymphatics.)

First Aid (Carrying the Injured) (Silent)

"Demonstrates the making and using of stretchers in emergencies and the methods of carrying injured persons without stretchers." (Eastman)

¼ Reel. $0.50 Service Charge (One day)

(Editor's Note: This film demonstrates the use of improvised stretchers, the three-man lift, the chair method of carrying injured and similar methods of transporting injured persons.)

Home Nursing (Routine Procedures) (Silent)

"Covers routine procedures in the care of a convalescent. The units are: (1) Taking Temperature, Pulse and Respiration; (2) Preparing Patient for Breakfast; (3) Serving Food; (4) Preparing Patient for the Night." (Eastman)

1 Reel. $0.75 Service Charge (One day)

Home Nursing (Special Procedures) (Silent)

"Some special procedures for relieving specific conditions. Wherever repeated applications are required, the proper lapse of time is indicated. The units are: (1) Cold Compresses; (2) Applying Hot Stupes; (3) Giving a Foot Tub to a Patient in Bed; (4) The Flaxseed Poultice; (5) Inhalations." (Eastman)

1 Reel. $0.50 Service Charge (One day)

Bell and Howell First-Aid Films

THE films listed below are available from the Bell and Howell Filmosound Library, 1801–1815 Larchmont Avenue, Chicago, Illinois. Each of the films listed below are available in four distinct variations. They are:

Black and white sound—16 mm. Rental each $1.50

Black and white silent—16 mm. Rental each $1

Color silent—16 mm. Rental each $3

Black and white—8 mm. Rental each $1

Be certain to specify the size and exact description of the film that you desire and indicate the rental price given.

1. Bleeding—Resuscitation—Shock

No. 500 The essential first steps to stop bleeding and to restore breathing and consciousness. Serious wounds, as well as more common incidents such as nosebleed, are dealt with. Paths of chief blood vessels and pressure points to check hemorrhage. Resuscitation technic. Treatment for shock and fainting.

2. Treatment of Wounds and Burns

No. 501 A standard first-aid kit examined and the chief items explained. Disinfectants. How to make and use applicators. Protection of sterile materials. Many widely varied applications of triangular and other bandages, from simple to most complex uses. Treatment for burns.

3. First Aid in Fractures

No. 502 Beginning with the simplest emergency splinting, the use of a newspaper or magazine for a forearm splint without traction, the reel takes the student step by step through more difficult tasks to the final splinting for a thigh fracture.

4. Fixed Traction Splinting

No. 503 Use of Thomas splints and other professional as well as improvised types—Reasons for traction.

5. Transporting the Injured

No. 504 First the best means of carriage, a regular Army type stretcher, and then several emergency types are demonstrated. Other means of transport, such as chair carriage, fireman's drag, etc., are shown in detail.

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Annual Subscription--------Three Dollars-Fifty Cents Single Copies--------Fifty Cents

Advertising Representative: Cooperative Medical Advertising Bureau, 535 North Dearborn St., Chicago, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, Madison

Volume 41 NOVEMBER, 1942 Number 11

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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« « « EDITORIAL » » »

As the "printer's dummy" for this issue of *The Journal* is being pasted, there is also being prepared for current mailing a detailed bulletin dealing with the subject of gasoline rationing under the Wisconsin procedures.

The editorial column of *The Journal* is happy to have this occasion to express the appreciation of the Society to the Office of Price Administration, under the direction of Mr. Don T. Allen of Milwaukee, for the cooperation and understanding that it has shown and the confidence placed by Mr. Allen in the medical profession. As *The Journal* goes to press, it is in receipt of a special news release from the American Medical Association on the subject. It expresses so well the thoughts that should be heeded by all physicians in Wisconsin that it is reprinted here in its entirety.

Chief of Gasoline Rationing Appeals to Physicians of U. S.

Vital Role They Will Play in the Program Is Emphasized in Open Letter Published in the Journal of the A. M. A.

AN OPEN letter to all physicians of the United States from the chief of the Gasoline Rationing Branch, Office of Price Administration, concerning the vital role they will play in the rationing of gasoline and tires, is published in the Medicine and the War section of *The Journal of the American Medical Association* for October 31.

The letter is as follows:

"In the East Coast Gasoline Rationing program, made necessary by the shortage of transportation facilities for petroleum products, the indispensability of your profession was recognized by its inclusion in the categories of persons eligible for preferred mileage, that is, necessary occupational mileage in excess of 470 miles a month. Now the Office of Price Administration has been ordered by Mr. William Jeffers to institute and administer a nationwide mileage rationing program for the express purpose of conserving our rubber-borne transportation. In framing the Regulations for the new program, your profession was one of the first to be provided for.

"If we are to carry out our double task of preventing a collapse of our military and civilian transportation, we must have the complete cooperation of those groups of persons whose driving is deemed essential to the war effort. Our immediate aim is to attain the 5,000 mile national mileage

average set by the Baruch Report as the maximum possible in light of the dire rubber shortage. Our experience with the East Coast program tells us that the preferred categories use one half of the gasoline consumed, though they constitute less than one fourth of the total number of automobile operators. Clearly, then, the great savings of rubber on a nationwide scale must be made in the preferred categories.

"Under the Regulations, governing the mileage rationing program, physicians are eligible for preferred mileage if their essential occupational needs exceed 470 miles a month and if the mileage is needed for regularly rendering necessary professional services. Mileage traveled daily or periodically between home or lodging and a fixed place of work is not considered preferred. Physicians who conduct their practices in offices, as many specialists do, are not eligible for preferred mileage.

"Without question or hesitation, doctors have been and will be granted all the gasoline needed to carry out their professional work. We hope that they will regard their concrete symbol of their indispensability, the C book, as a moral obligation and not as a personal privilege. From another point of view, the C book is part of a doctor's equipment; it should not be used for anything but the work of humanity.

"When nationwide gasoline rationing begins, there are certain concrete things a doctor can do to live up to the high ethical standards set for him by his own profession:

"1. At the time of first issuance of rations, he can so carefully compute his necessary mileage as to make a B book adequate for his purposes though he might easily make out a case for a C book, which might be granted to him without question by his local War Price and Rationing Board eager to provide for physicians.

"2. In the computation of his mileage, he can religiously adhere to the provision of the Regulations, which makes 150 miles of his basic ration available for occupational purposes. Moreover, he can help mightily in establishing the principles that only 90 miles of the basic ration are to be used for home necessary use and that there is no provision whatever in any ration for 'pleasure driving.'

"3. Conversely, if he should be granted a C book, he can return to the local board, at the end of the three months period, all unused coupons accruing to him as a result of a quite natural overestimation of needs or of overgenerous 'tailoring' by his board, instead of using such coupons for nonessential purposes. The moral effect of such an act on his fellow citizens will be incalculable.

"4. He can set an example by scrupulously observing the 35 mile speed limit, except in cases of emergency, in spite of the fact that doctors could easily 'get away with it.'

"5. Should he be assigned to a hospital, clinic or institution after a ration card for calling on his private practice has been issued, he can use public means of transportation at the price of personal inconvenience.

"6. He can refrain from any kind of driving whatever which might appear to be nonessential in the eyes of the public.

"Doctors are the leaders and molders of public opinion in their communities. If the average man has any reason to believe that the professional men whom he regards with great respect are indifferent or hostile to the mileage rationing program, it will be difficult, if not impossible, to make it effective. Conversely, if doctors as a group observe the letter and spirit of the Regulations, they will be a powerful force in making this absolutely mandatory war measure serve its purpose. We know that we can rely on the support of your profession, which has demonstrated its patriotism, ability and unselfishness at every opportunity.

"John R. Richards,

"Chief Gasoline Rationing Branch, Office of Price Administration."

Commenting on Mr. Richards' letter, *The Journal* says that "It calls on the medical profession not only to comply fully with the actual stipulations relative to the rationing of gasoline and tires but also to go beyond such limitations into the spirit of the effort which is so intimately concerned with the winning of the war. Doctors should adhere religiously to the provisions of the regulations and should set an example to all other persons in the community by the economy with which they use these materials. When Mr. John R. Richards says that doctors are the leaders and molders of public opinion in their communities, he recognizes the dependence of the public on medical leadership in all matters concerned with health. Already such recognition has come from the director of the Fuel Rationing Division. Physicians are authorized to certify invalids, old people and infants for extra fuel oil. Mr. Joel Dean, director of this division, points out that the rationing boards will naturally rely largely on physicians' certification. He says 'If these auxiliary rations are granted with unjustified liberality, the effectiveness of the entire effort to distribute this scarce commodity equitably and to assure continuance of oil for industrial processes in war plants will be jeopardized. I am sure that the medical profession, when it realizes the seriousness of this additional responsibility, will discharge it conscientiously and patriotically.' The patriotism of the medical profession has never been questioned. In this great war physicians have demonstrated their support by their magnificent enlistment in the armed forces and by assuming innumerable obligations in relationship to the control of civilian life. Let us, by the manner in which we aid in the programs for the rationing of fuel, gasoline and tires, demonstrate again to the people of America that confidence in and dependence on the medical profession is well warranted."

H. R. 7534

PRESIDENT ROOSEVELT, in his budget message to Congress in January of this year, recommended "an increase in the coverage of old-age and survivors' insurance, addition of permanent and temporary disability payments and hospitalization payments beyond the present benefits programs, and liberalization and expansion of unemployment compensation in a uniform national system."

Long-awaited, the proposal now stands before Congress in the form of H. R. 7534, introduced by Representative Eliot of Massachusetts. In substance, the measure is said to provide for systems of disability insurance benefits, including medical, surgical, institutional and other services to be supplied by the Social Security Board, as well as for temporary disability and maternity benefits, and, as specifically suggested, for certain hospitalization benefits of not less than $3 nor more than $6 for each day of hospitalization, such benefits to be available to the wife and children of the employe.

Increased contributions by both employer and employe would be required, with administration of the proposal through the Social Security Board. In addition to cash disability benefits, the Board would be empowered to "make provisions" for the furnishing of medical, surgical, institutional, rehabilitation, or other services to individuals entitled to cash disability benefits, if such services may aid in enabling the individuals to return to gainful work. It is said that the hospitalization benefits would be made available to the employed individual, and to his wife and dependent children, and would consist of an amount not less than $3 nor more than $6 for each day of hospitalization. Arrangements to carry into effect this provision would be through the Social Security Board, acting in consultation with a so-called Advisory Hospital Benefits Council.

H. R. 7534 is of vital concern to all people. Any proposal which in fact if not in theory, and perhaps in theory as well as in fact, or in theory only, affects the system under which the great benefits of present-day hospitalization and medical care have been delivered to the people, must be subjected to the most careful scrutiny by all. C. H. C.

Will Respond

THE October 31 issue of the *Journal of the American Medical Association* contains a statement by the directing board of the Procurement and Assignment Service of particular significance to all physicians. Because of its importance, it is quoted here in full:

"The directing board of the Procurement and Assignment Service is pleased to announce that 95 per cent of the 1942 procurement objective of medical officers for the armed forces has already been met. Toward this total a number of states have supplied more than their share of physicians and only a few states are lagging behind in their quotas. It is from these states that the additional physicians needed during the current year should come.

"The recruitment of such a large number of physicians in a few months is a remarkable achievement and another demonstration of the traditional patriotism and unselfishness of the medical profession. In this achievement, and particularly in its members who are "in service," the profession can justifiably take pride.

"The end, of course, is not yet. Increases in the armed forces will necessitate more medical officers, and additional demands will be made on the profession for medical services in critical war production areas. The directing board is convinced, however, that the physicians of this country will respond to future calls for service, whatever they may be, in the same splendid manner with which they have already volunteered for service with the armed forces."

. . . . THE PRESIDENT'S PAGE . . . .

The Year Ahead

WITH this issue of *The Journal*, I accept my first assignment of The President's Page. In the years in which I have been associated with the Society, I have come to think of the days of the September meeting as marking the beginning of a new year for the State Medical Society of Wisconsin. But, upon reflection, it seems obvious that with the opening of a new year of activities, the Society does not wipe its slate clean and initiate completely new policies and procedures. Rather, it continues in a spirit of vigor and with a sense of responsibility to seek those objectives upon which its organization has been predicated for so many years.

That its affairs during this coming year will be complicated by the exigencies of the national emergency seems only too apparent. Innumerable of its members are in military service, and those remaining at home are confronted with a multitude of new responsibilities and new duties not alone to carry forward the standards of public health, but to share with each other those responsibilities which have been left to us by those who have entered service. Despite all of this, and despite the fact that the profession of medicine will be burdened as never before in its history, I feel it is incumbent upon me, as your president, to emphasize that in the medical organization these procedures, many of which are of time honored value, are not of less importance but, on the contrary, are of even more importance than prior to the entrance of this country into World War II. Despite gasoline rationing, tire rationing and the demands upon our time, it becomes incumbent upon all physicians to continue their professional meetings, that in them they may find the stimulation and the education that arises from scientific discussions among physicians.

The House of Delegates very prudently, in my judgment, has increased the dues for 1943 in a moderate amount, that we may maintain the pledge we have made to those who have entered service, that the essential activities and the strength and value of the medical profession will continue as they have before, vital to the public health and to the science of medicine.

To the county society secretaries who contribute so generously and wholeheartedly of their time and effort in maintaining the strength of the profession locally, I pause to give a word of commendation and to seek their further assistance in the year ahead. Their responsibility of developing the policies and procedures on the local level is equally as great as that of the president of the Society, who must inspire with his leadership, and of the secretary who must provide the cohesive strength to the organization and to the work of the officers, committees and members.

The House of Delegates has recognized the real responsibility of the local officers by endorsing a suggestion to the effect that at the next annual meeting of the Society, there be provided a special opportunity for the county society secretaries to meet and discuss mutual problems, and to attend the first and subsequent sessions of the House of Delegates as the specially invited guests of that body.

The first year of our second century of existence drew to a close with the One Hundred First Anniversary Meeting. We enter the year ahead with a spirited group that is interested in our Society, convinced of its value, determined to continue those policies which have contributed to the fundamental strength and growth of the medical profession.

It can truly be said that with our course now fixed, our sails are up and all of us are at the tiller.

F E Beitler

KEEP 'EM WORKING

Industrial Medical and Surgical Clinic

HOTEL SCHROEDER, MILWAUKEE, NOVEMBER 17

"I've Read the Program! I'm Going!"

THAT statement was made by a member of the Society when he was asked if he had noticed the announcement of the Postgraduate Industrial Medical and Surgical Clinic in the October issue of *The Wisconsin Medical Journal.* Since the release of the last *Journal* and the special bulletin on round-table luncheons, repeated comments have been made by members commending the program both as to the topics selected and the faculty obtained to discuss them.

The timeliness of the presentation of the meeting on the medical and surgical aspects of the care of Wisconsin's manpower is evidenced by the emphasis which was placed on the factory worker and the farmer in the recent radio address of President Roosevelt. In that address the President declared that we have two main objectives in our war effort. The first is the development of our armed forces. The second is ". . . **to man our war industries and farms with the workers needed to produce the arms and munitions and food required by ourselves and our fighting allies to win this** war." After an extensive trip through the United States, the President was impressed with the importance of the farmer in our war program and emphasized to us that "**Every farmer in the land must realize fully that his production is part of war production, and that he is regarded by the nation as essential to victory.**"

The importance of returning workers to their tasks was outlined in the October *Wisconsin Medical Journal* when it was stated that "Farm workers form as important a link in our war industries as do the men at the lathe or on the assembly line. . . . The farmer must produce the supplies necessary to keep our war industries moving."

The "KEEP 'EM WORKING" slogan was chosen for this meeting in emphasis of the fact that the Committee on Industrial Health and the Council on Scientific Work are fully cognizant of the importance of returning every man and woman to work as soon as possible, insofar as is consistent with good medical practice. Wisconsin physicians have been justly proud of the enviable record they have aided so materially to build, that of keeping the number of days the average worker loses down to two days per year. This remarkable record is five times better than that of the nation as a whole and from six to nine times better than that experienced in foreign countries prior to the present war. The employment of those in the older age groups, an increased number of women in industry, and the speed at which we must work today have accounted for an increase in the average number of days lost by Wisconsin workers. In order to equip our members better to care for Wisconsin manpower this program on industrial health subjects has been so arranged as to enable members to render even more efficient service than that which has characterized Wisconsin medicine in the past.

An added responsibility of the physician on the home front is to become better informed on the recent advances in the treatment of industrial injuries and diseases.

Evening Session

MR. W. D. JAMES

The evening meeting which forms an integral part of the Postgraduate Industrial Medical and Surgical Clinic will be opened by a dinner at 7:00 p. m. Immediately following the dinner Mr. William D. James, president of the James Manufacturing Company of Fort Atkinson, manufacturers of James Way farm equipment and scaffolding, will speak on "Health in Industry."

MR. A. T. COURT

Several years of study will be represented in the message to be brought to Wisconsin by Mr. Andrew T. Court of the General Motors Corporation of Detroit when he will discuss "Sickness Absenteeism in Industry."

Elaborate arrangements have been made to give all employers in Wisconsin an opportunity to attend this meeting. Physicians planning to attend the clinic are urged to invite employers in their communities to come to Milwaukee with them on November 17. These employers will undoubtedly have other business to transact during the daytime and will then be able to attend the evening dinner as the physicians' guests.

Round-Table Luncheons

So popular have round-table luncheons proved to be that no scientific program is complete now without them. A series of ten noon round-table luncheons has been arranged for the November 17 meeting. A special bulletin was issued on October 24 which brought an outstanding response. Prompt reservations give greater assurance that the round tables of greatest interest to the individual physician will still have room available. If you have not already done so, you are urged to forward your reservation at once for one of the round-table luncheons listed on page 1029. In forwarding your reservation it is important to designate your first, second and third choices in order that you may attend one round-table luncheon of particular interest to you.

Scientific Exhibits

Scientific exhibits have so effectively demonstrated their value as an educational medium that a series of them has been arranged for display at the Postgraduate Industrial Medical and Surgical Clinic. These exhibits will be located on the same floor as the general sessions. The didactic lectures will be given in a portion of the Crystal Ballroom, and the industrial scientific exhibits will be on display in the Banquet Room. Both are located on the fifth floor of the Hotel Schroeder.

Elsewhere in the section of *The Journal* devoted to the meeting you will find a complete description of each of the exhibits which will be shown. Among the exhibits will be found those of the American Medical Association on "Amputations," "Industrial Health Program for a County Medical Society," "Pneumoconiosis," "Asbestosis," "Silicosis," and "Tuberculosilicosis." Other scientific exhibits to be presented are: "Industrial Dermatosis" by Harry R. Foerster, M. D., Milwaukee; "Lead Poisoning" by Elston L. Belknap, M. D., Milwaukee; "Allergies in Railroad Workers" by the Southern Pacific Railroad; and an exhibit by the Metropolitan Life Insurance Company. Members of the Society who had an opportuninty at the annual meeting hobby show to see the soap carvings showing different types of fractures, which were made by Dr. Arthur V. de Neveu of Milwaukee, commented so highly on them that they have been obtained for a further showing at the Postgraduate Industrial Medical and Surgical Clinic.

GUNNAR GUNDERSEN

F. D. MURPHY

PROGRAM

MORNING

General chairman—Dr. Gunnar Gundersen, La Crosse, chairman, Committee on Industrial Health

8:30– 9:00 Scientific Motion Pictures.
Dermatosis of Industrial Workers.

9:00– 9:05 Introduction by the chairman outlining the significance of this meeting.

9:05– 9:20 The Physician's Responsibility Under the Workmen's Compensation Act.
Mr. Harry A. Nelson, director, Workmen's Compensation Division, Industrial Commission.

9:20– 9:50 The Evaluation of Disability in Industrial Injuries.
Dr. Merritt L. Jones, Wausau

9:50–10:10 Knee Joint Injuries and Their Treatment.
Dr. James R. Regan, Milwaukee

10:10–10:20 Recess.

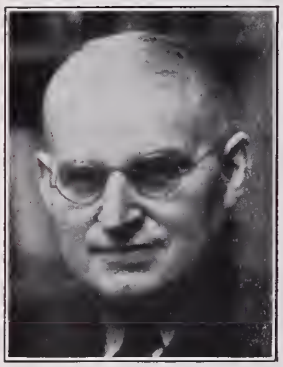
10:20–10:40 Medical Control of Poisons in Industry.
Dr. Elston L. Belknap, assistant clinical professor, Marquette University School of Medicine, Milwaukee

10:40–11:00 The Handicap of Hernia in Industry.
Dr. Raymond W. McNealy, associate professor of surgery, Northwestern University Medical School, Chicago

11:00–11:20 Reduction of Disabilities in Fracture Management.
Dr. Chester C. Schneider, Milwaukee

11:20–11:40 Traumatic Shock.
Dr. Carl W. Eberbach, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee

11:40–12:10 Hospital Facilities and Inadequacies during the Accelerated Program.
Dr. Harry W. Sargeant, superintendent, Milwaukee County Hospital, Milwaukee



E. R. SCHMIDT

C. C. SCHNEIDER

M. L. JONES

R. W. McNEALY

J. A. REGAN

C. W. EBERBACH

MR. H. A. NELSON

J. O. DIETERLE

12:10—1:45 ROUND-TABLE LUNCHEONS

1. The Standard Outline Used in Estimating Disability
   Dr. Merritt L. Jones, Wausau
   Parlor C
2. Injuries and Dislocation of the Shoulder
   Dr. James R. Regan, Milwaukee
   Parlor D
3. Poisons in Industry
   Dr. Elston L. Belknap, Milwaukee
   Parlor E
4. Crushing Injuries to the Feet
   Dr. Chester C. Schneider, Milwaukee
   Parlor F
5. Traumatic Abdominal Injuries
   Dr. Raymond C. McNealy, Chicago
   Parlor I
6. Wounds of Soft Parts and Their Management
   Dr. Carl W. Eberbach, Milwaukee
   Room B
7. Skull Fractures
   Dr. Harry E. Mock, Chicago
   Room C
8. The Coronary Artery in Industry
   Dr. Newell C. Gilbert, Chicago
   Room D
9. Rehabilitation Following Fractures
   Dr. Herman C. Schumm, Milwaukee
   Room E
10. The Physical Examination in Industry
    Dr. Russell M. Kurten, Racine
    Committee Room

AFTERNOON

2:00– 2:20 Injuries to the Scalp, Skull and Brain.
Dr. Erwin R. Schmidt, professor of surgery, University of Wisconsin Medical School, Madison

W. E. GROVE

J. L. GARVEY

N. C. GILBERT

H. C. SCHUMM

H. E. MOCK

S. E. GAVIN

E. J. CAREY, M. D.

R. M. KURTEN

2:20– 2:40 Anatomical and Constitutional Aspects in Differential Diagnosis of Low Back Pain.

Dr. Harry E. Mock, Chicago

2:40– 3:00 Anatomical Considerations in Back Injuries.

Dr. Eben J. Carey, dean and professor of anatomy, Marquette University School of Medicine, Milwaukee

3:00– 3:20 Hiatus Hernia.

Dr. N. C. Gilbert, professor of medicine, Northwestern University Medical School, Chicago

3:20– 3:30 Recess.

3:30– 3:50 Common Fractures and their Treatment.

Dr. Herman C. Schumm, associate professor of orthopedic surgery, University of Wisconsin Medical School; clinical professor of orthopedic surgery, Marquette University School of Medicine, Milwaukee

3:50– 4:10 Intervertebral Disc Diseases.

Dr. John O. Dieterle, Milwaukee

4:10– 4:30 Therapy of Burns.

Dr. Stephen E. Gavin, Fond du Lac

4:30– 4:50 Neuritis Following the Use of Serum.

Dr. John L. Garvey, clinical professor of neurology, Marquette University School of Medicine, Milwaukee

4:50– 5:10 Ear and Eye Complications of Cranio–Cerebral Injuries.

Dr. William E. Grove, Milwaukee

7:00 **Employer–Physician Dinner**

Health in Industry.

Mr. William D. James, president, James Manufacturing Company, Fort Atkinson

Sickness Absenteeism in Industry.

Mr. Andrew T. Court, General Motors Corporation, Detroit.

The Scientific Exhibits

Treatment of Burns

A. A. Schaefer, Milwaukee

As a result of burns, 53,000 working days were lost by Wisconsin workers in 1941 at a cost of $173,384 for indemnity and medical fees combined. Several types of treatment will be shown in this exhibit. Pictures will show cases of severe burns, the treatment employed and the results. Plastic procedures employed to correct contractures will also be demonstrated.

Industrial Dermatoses

H. R. Foerster, Milwaukee, and Louis Schwartz, United States Public Health Service, Bethesda, Maryland

As a result of industrial dermatoses, 8,000 working days were lost to workers and industry in 1941 at a cost of over $34,000. The exhibit contains a description of some of the causes of industrial dermatoses, the clinical types, diagnosis, treatment and prevention of dermatoid conditions encountered in

industrial plants, offices and factories. Included in the exhibit are approximately fifty photographs and several small charts.

Treatment of Frostbite of the Extremities

J. Ross Veal and Roy G. Klepser, Gallinger Municipal Hospital, Washington, D. C.

This exhibit demonstrates the tissue and vascular changes in the various stages of freezing of the extremities, supplemented by experimental studies on animals; photomicrographs illustrating pathology of the tissue and vascular system; colored photographs of the three degrees of frostbite; arteriographs illustrating the vascular changes; a comparative study of the effects of exposure to cold on the normal person, on the alcoholic and on those persons with pre-existing vascular damage; and an outline of treatment for the various stages. Frostbite accounted for 312 days of industrial disability in Wisconsin in 1941.

Health Progress and American Man Power

D. B. Armstrong and Louis I. Dublin, Metropolitan Life Insurance Company, New York

This is an exhibit of a series of charts showing the great reduction in mortality during the last thirty years as a result of the improved control of the principal diseases and conditions existing during this period, the effect of this reduction upon the average length of life, and the resulting gains in America's man power to meet our present emergency.

Soap Carvings of Fractures

A. V. de Neveu, Milwaukee

This is a striking display of soap carvings showing the number of different types of fractures, including portrayals of fractures of the tibia and fibula, toes, humerus, ulna, femur and radius.

Pneumoconiosis

American Medical Association

This is an exhibit prepared for the Council on Industrial Health by the Saranac Laboratory consisting of transparencies and posters dealing with the causes, symptoms, physical signs and diagnosis of benign non-specific pneumoconiosis.

Silicosis

American Medical Association

This is an exhibit prepared for the Council on Industrial Health of the American Medical Association by the Saranac Laboratory, consisting of transparencies and posters dealing with the causes of silicosis, the principal sources of silica hazards, the essential factors in the production of silicosis, atmospheric concentration of dust, and individual susceptibility. This disease resulted in 48,000 days of disability to Wisconsin workers in 1941.

Tuberculosilicosis

American Medical Association

This is an exhibit prepared for the Council on Industrial Health of the American Medical Association by the Saranac Laboratory, consisting of transparencies and posters dealing with the symptoms, signs and clinical course of silicosis with tuberculosis and tuberculosilicosis.

Asbestosis

American Medical Association

This is an exhibit prepared for the Council on Industrial Health of the American Medical Association by the Saranac Laboratory, dealing with the symptoms, physical signs, clinical course, diagnosis and prevention of asbestosis.

An Industrial Health Program for a County Medical Society

American Medical Association

This is an exhibit from the Council on Industrial Health of the American Medical Association consisting of posters showing the organization and activities of an industrial health program for a county medical society.

Amputations

American Medical Association

This is an exhibit from the Council on Physical Therapy of the American Medical Association, consisting of manikins showing the most suitable sites for leg amputations, together with charts and posters showing the most suitable sites for finger amputations. A pamphlet containing information about the exhibit will be distributed. Amputations were responsible for the loss of 219,474 working days to Wisconsin workers and industry in 1941. The cost of indemnity and medical fees totaled $501,444.

Lead Poisoning

Robert A. Kehoe, University of Cincinnati College of Medicine, Cincinnati

This is an exhibit depicting by drawings and photographs the sources of exposure, charts demonstrating physiologic reactions to various magnitudes of exposure, diagnostic criteria and methods of recognizing and measuring lead exposures.

Dairy Foods For Workers

Committee on Health and Public Instruction, State Medical Society of Wisconsin

Emphasis will be placed on the value of dairy products to the workers in factories and offices. Data obtained from the Wisconsin Alumni Research Foundation will be included. Nutritional facts concerning cheese, butter, milk and meat will be outlined. Slides portraying the importance of dairy products in industrial workers' nutrition will be projected continuously in the booth. Extra copies of

the supplement to the June issue of *The Wisconsin Medical Journal*, in which were reprinted articles on nutrition appearing in earlier issues of *The Journal*, will be available.

Industrial Hygiene Unit of the State Board of Health

Paul Brehm, Director

This is a display of equipment used by the Industrial Hygiene Unit in taking samples of fumes, dusts, vapors and gases in Wisconsin factories.

Charts showing the absenteeism in Wisconsin will also be shown. Wisconsin's absenteeism, which can be still further reduced, is lower than any other state in the country. In 1939 the average employe lost two and one-half days of work due to illness or accident. The following year this dropped to two and one-quarter days, and in 1941, in spite of adverse factors such as the employment of inexperienced workers, older workers, a greater ratio of women workers, and accelerated production, the rate remained at the enviable low record of two and one-half days.

Eye Efficiency Speeds Victory

National Society for the Prevention of Blindness

The individual illustrations in this exhibit show factors in increased production, such as: good eyes, prescription lenses; goggles; light, paint, cleanliness; safe work surroundings; guarding at source; first aid; and periodic eye check-up.

News Items and Personals

The Wisconsin Welfare Council held its biennial conference in Milwaukee on October 8, 9 and 10. Among the speakers were *Dr. Ralph M. Fellows*, assistant medical director at Milwaukee County Hospital for Mental Diseases, who discussed mental hygiene, Dr. M. T. MacEachern, Chicago, of the American College of Surgeons and *Dr. Gerald F. Burghardt*, Milwaukee, city deputy commissioner of health.

Among speakers of national and international prominence were Lady Simon of Manchester, England, who outlined British welfare experience in wartime; President Clarence A. Dykstra of the University of Wisconsin, who spoke on post war reconstruction; William Haber of the War Manpower Commission, whose topic was manpower allocation in wartime; and John Weigel, Chicago, regional director of OPA, who spoke on "Coming Changes in Our Standard of Living."

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Dr. Eben J. Carey, dean of the Marquette University School of Medicine, and *Dr. Russell M. Kurten*, Racine, president-elect of the State Medical Society of Wisconsin, were the principal speakers at the eighteenth postgraduate medical program held in Madison on October 3 under the auspices of the Jackson Clinic and members of the Marquette University School of Medicine.

Dr. Carey spoke on "War and Medical Education," and Dr. Kurten on "Recent Developments in Medical Economics."

Other members of the Marquette staff who spoke were *Dr. Fredrick A. Stratton*, professor of surgery, and *Dr. Joseph M. King*, associate clinical professor of surgery.

Drs. John T. F. Gallagher and Harold E. Marsh, Madison, held diagnostic clinics during the morning, and *Drs. Luther E. Holmgren, Albert W. Bryan, James A. Jackson*, and *Addie M. Schwittay*, all of Madison, led discussions.

Dr. George H. Irwin, Lodi, was honored by his fellow Rotarians at a public meeting in Lodi on October 5. Dr. Irwin has served his community as physician for fifty-four years. He has been public health officer of the villages of Lodi and Okee and for the townships of Lodi and West Point for almost thirty years. *Dr. Clair O. Vingom*, Madison, president of the Dane County Medical Society, of which Dr. Irwin is a member, was the chief speaker.

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A new weapon for the war that never ends, man's fight against disease carrying microbes, was explained in sound motion pictures to doctors and industrialists at the Milwaukee Athletic Club on October 14.

The weapon is a gas filled tube which emits a pale blue light that is sure death to air-borne bacteria. Already its deadly rays are safeguarding human lives in nurseries, operating rooms and schools.

Robert James, a little known scientist, had the original idea for the ray. He knew that the sun has a band of natural light which destroys microbes, so he tackled the problem of duplicating these rays artificially.

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Dr. Fred A. Nause, Sheboygan, chief of Emergency Medical Service for Sheboygan County, spoke before a rally of the County Nursing Council of the Sheboygan County Council of Defense on October 8. Dr. Nause's topic was "The Role of Nurses in the Emergency Medical Service."

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At a staff meeting of the Wisconsin General Hospital on September 22, *Dr. William D. Stovall* spoke on "Problems in Clinical Laboratory Diagnosis." On October 6 *Dr. Anthony R. Curreri* spoke on "Water Balance." On October 20 Dr. Fritz Kant spoke on "Psychiatry for the General Practitioner," and on November 3 *Dr. Hans H. Reese* spoke on "Neurologic Disorders Seen in General Practice."

Presentation of the coveted Army–Navy "E" pennant to E. R. Squibb and Sons was witnessed by more than 2,000 employees in the grand ballroom of the Waldorf–Astoria Hotel, New York City, on September 18. The pennant was presented by Rear Admiral Harold W. Smith, (MC) USN, chief of the Navy's Research Division of the Bureau of Medicine and Surgery, to Mr. Carleton H. Palmer, chairman of the Squibb board.

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The Ninth Institute on Public Health Education was held in St. Louis on October 24, 25, 26, and 27, in connection with the Seventy-First Annual Meeting of the American Public Health Association.

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One of the largest and most complete collections of bound medical journals in the country, which belonged to the late Dr. Ralph M. Carter, Green Bay, has been turned over to the Committee on Aid to Libraries in War Areas by Mrs. Carter. More than fifty cartons of bound journals have already been packed and shipped to Milwaukee Downer College for storage, and as appeals come in for certain journals they will be taken from the Carter collection and sent to depleted libraries.

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At a meeting of the Milwaukee district of the Wisconsin State Nurses' Association, on October 13, *Dr. Marcos Fernan–Nunez* of Milwaukee addressed more than 300 nurses on the subject of "Malaria."

The talk was planned for the benefit of many of the nurses who are about to be commissioned second lieutenants and will join the fighting forces in tropical countries.

The meeting was held at the Marquette Medical School Auditorium. More than 100 student nurses from about twenty-five Milwaukee hospitals were guests of the association.

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Dr. John M. Dodd, Sr. has been appointed as city physician for the City of Ashland to replace *Dr. George W. Harrison*, who is now in service with the armed forces.

Members of the Wisconsin Clinical Surgical Club met on October 17 with *Dr. Victor F. Marshall* at St. Elizabeth Hospital, Appleton. The meeting was devoted to the reading of papers and presentation of cases and surgical movies.

A luncheon was held at the Colonial Wonder Bar.

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Announcement has been made by *Dr. Hans H. Reese*, president of Normandale, that the sanitarium will be closed on November 1 for the duration of the war because *Dr. Marvin F. Greiber*, medical director, is entering military service and because of the difficulty in obtaining employees.

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The American Gastroenterological Association will publish on January 1, 1943, the first issue of a new journal to be called *Gastroenterology*. It will appear monthly and will be owned by the Association. Dr. W. C. Alvarez of Rochester, Minnesota, will be the editor after June, 1943, and Dr. A. C. Ivy, Chicago, Illinois, will be the assistant editor.

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Dr. Florence R. Sabin, Denver, Colorado, and Dr. David T. Smith, Durham, North Carolina, will be guest speakers at Dearholt Day Institutes to be conducted by the Wisconsin Anti-Tuberculosis Association in Milwaukee, November 16, and in Madison, November 17. Cooperating with the W. A. T. A. in the institutes are the Marquette University School of Medicine, the University of Wisconsin Medical School, the Dane County Medical Society, the Tuberculosis Division of the Milwaukee Health Department, Muirdale Sanatorium and the Milwaukee Academy of Medicine.

The institutes are held in memory of the late Dr. Hoyt E. Dearholt, executive secretary of the W. A. T. A. from the time it was founded in 1908 until his death in 1939. Dr. Sabin will speak on "Research in Tuberculosis" and Dr. Smith "Diagnosis of Non-Tuberculous Pulmonary Diseases."

Minutes of the Council; Milwaukee, September 13, 1942

1. Dinner

The Council and guests met for dinner at 12:00 noon in the English Room of the Hotel Schroeder, Milwaukee, on Sunday, September 13, 1942, preceding the One Hundred First Anniversary Meeting of the Society.

2. Call to Order

Following dinner, the Council was called to order by Chairman Gavin at 1:45 p. m.

3. Roll Call

The following members of the Council were present, constituting a quorum: Councilors Gavin, Lambert, Gramling, Krahn, Blumenthal, Bowen, Pippin, Jegi, Christofferson, Pechous, Clark, Arveson, Fitzgerald and Heidner; President Gundersen; President-elect Butler; Past-president Sproule; Treasurer Sisk; Speaker Kurten.

Invited guests included Vice-speaker Fidler; Dr. Eben J. Carey, president-elect, Medical Society of Milwaukee County; Mr. James O. Kelley, executive secretary, Medical Society of Milwaukee County; Dr. C. A. Dawson, River Falls, chairman, Committee on Public Policy; Dr. C. A. Harper, Madison, state health officer and secretary, State Board of Health; Dr. C. N. Neupert, Madison, assistant state health officer; members of the Subcommittee on Procurement and Assignment Service of the Committee on War Participation—Dr. P. R. Mina-

han, Green Bay; Dr. F. X. Pomainville, Wisconsin Rapids; Dr. H. M. Coon, Madison; Dr. J. W. Prentice, Ashland; in addition to Dr. Eben J. Carey; Dr. T. J. O'Leary, Superior, past-president; Dr. S. Z. Giffin, chairman of the Council, Minnesota State Medical Association. Besides Drs. Dawson, Arveson and Christofferson, other members of the State Board of Medical Examiners present included Dr. Ernest Miller, Milwaukee, and Dr. Jessie P. Allen, Beloit.

Also present as guests to participate in discussion which followed, were Dr. C. H. Phifer, Sixth Service Command Chairman, Procurement and Assignment Service, Chicago, and Colonel R. F. Olmsted, Sixth Service Command Headquarters, Chicago, representing the medical recruiting program. Both Secretary Crownhart and Assistant Secretary Larson were present. Guests were introduced by Chairman Gavin.

4. Approval of Minutes of July Meeting

Minutes of the July meeting of the Council, as published in the August issue of *The Wisconsin Medical Journal*, were unanimously approved.

5. The Procurement and Assignment Service and the Recruiting of Medical Officers in Wisconsin

For the information of the Council, Chairman Gavin called upon Dr. C. H. Phifer, Chicago, as chairman for the Procurement and Assignment Service for the Sixth Service Command, to discuss the subject of his agency, after which Colonel R. F. Olmsted, Chicago, discussed medical recruiting in Wisconsin. A general discussion of both subjects followed involving the effort in recruiting of medical officers in Wisconsin, results accomplished to date, problems involved under the Procurement and Assignment Service, and what might be expected in the future. No specific Council Action was sought.

6. Reduced Dues Classification of Membership for Graduates and Residents in Training

After re-referring the above matter to the Committee on Constitution and By-laws for further advice, the Council heard the report of the committee, which included the following proposed amendment to the By-laws:

> "Amend Chapter XI, Section 3, by the insertion of a paragraph to read:
>
> "By proper provision of Constitution and By-laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of three years from the date of such election, and shall not be included as a 'fully paid' member as that term is used in Section 2 of Chapter III."

After discussion, it was moved by Clark–Krahn that the resolution contained in the committee report be adopted. Carried unanimously. The resolution was then referred to the House of Delegates for action.

7. The Committee on Nursing Education

Dr. C. A. Harper, as secretary of the State Board of Health, presented a request that the Society submit a list of five nominees from among which an appointment might be made to fill a vacancy on the Board's Committee on Nursing Education, effective January 1, 1943, caused by expiration of the term of Dr. W. A. Munn, Janesville. It was variously moved, seconded, and carried, that the membership of the Society's Committee on Nursing Problems be suggested to the Board, Dr. Munn being chairman of that committee, and that a fifth member be appointed in the person of Dr. R. M. Kurten, of Racine. Chairman Gavin authorized such appointment.

8. Honorary Membership

Action having been taken by the Douglas County Medical Society in the matter of making Dr. Fred G. Johnson, Sr., an honorary member of that society, it was moved by Arveson–Jegi, and unanimously carried, that honorary membership in the State Medical Society of Wisconsin be voted to Dr. Johnson in recognition of his long and many services to medicine and the public health, and that he be so notified.

9. Report of the Auditing Committee of the Council

Chairman Gavin called upon Dr. H. H. Christofferson, Colby, to present the report of the Auditing Committee, of which he is chairman. Dr. Christofferson's report follows:

"REPORT OF THE AUDITING COMMITTEE OF THE COUNCIL TO THE COUNCIL OF THE STATE MEDICAL SOCIETY OF WISCONSIN

"The Auditing Committee of the Council is composed of Doctors H. H. Christofferson, Colby, chairman; G. W. Krahn, Oconto Falls; and Henry J. Gramling, Milwaukee. All three members of the committee met in the offices of the State Medical Society of Wisconsin, 917 Tenney Building, Madison, on September 3, 1942, and received the report of the auditor of the Society as it relates to the secretary's receipts and disbursements, the treasurer's account, the Wisconsin Medical Journal, and other matters.

"The entire day was spent in going over the financial affairs of the Society. A detailed examination was made of the individual itemized vouchers for the year 1941, and it was found that the voucher for each bill paid was properly allocated and supported the check issued. The committee examined the reports presented and the books of the Society, and found all in order. Actual inspection was made of the bonds held by the Society in safekeeping at the First National Bank of Madison and they were found to be properly reported in the treasurer's account.

"During the calendar year 1941, the Society's membership income was as follows:

1938 delinquent dues	$ 30.00
1939 delinquent dues	49.00
1940 delinquent dues	1,127.57
1941 dues	60,310.40
Total	$61,516.97
Less refunds to men in service	678.50
Net 1941 dues income	$60,838.47

In addition, $1,450 was received in the latter part of 1941 for the 1942 dues account which did not constitute part of the actual income for purposes of the 1941 budget.

"A condensed financial statement of the Society as of December 31, 1941, may be stated as follows:

1. Membership income, 1941, as detailed above	$60,838.47	
2. Interest on investment securities	715.00	
3. Interest on insurance proceeds, life of George Crownhart, left on deposit	107.31	
Total		$61,660.78
4. *Less* budget disbursements for 1941—This item includes net budget support given established Society revolving funds, such as the annual meeting account	$52,477.22	
5. *Less* also carry-over appropriations by custom carried from year to year	6,306.45	
6. Total deductions from Income		$58,783.67
7. Excess of income noted in items 1, 2 and 3 over budget expenses and allocations		2,877.11
8. Face amount of bonds held by the Society		29,000.00
9. Principal retained on deposit by insurance company (insurance on J. G. Crownhart)		9,457.60
Surplus, total		$41,334.71

"The secretary's office makes regular remittances to the treasurer of all cash received from any source whatsoever. Petty cash amounts are handled by check, with an accounting. We are satisfied that proper safeguards in the handling of the Society's funds are well established, and the committee desires to commend, in behalf of the Society, the treasurer of the Society and the secretary, for the manner in which the financial affairs of the Society are conducted.

"In addition, the committee conducted a physical inspection of the Society's property and found the office in good order and the property well maintained. The committee suggests to the councilors and other members of the Society that as occasion permits, they avail themselves of an opportunity to visit the offices in Madison to ascertain the procedures undertaken in the Society's interests.

"The committee viewed the filing system, various office procedures including publication of the Wisconsin Medical Journal, and met the office personnel.

"The committee desires to express its belief that the burdens of the office are increasingly complicated, and that the size of the present staff is hardly adequate to meet the many demands made upon the Society from both within and without the medical profession. It commends the treasurer for the careful attention he has given to the Society's investments and, on the whole, reports a satisfactory 'state of the union.'

THE AUDITING COMMITTEE OF THE COUNCIL,
H. H. Christofferson, M. D., Colby, *Chairman*
G. W. Krahn, M. D., Oconto Falls
Henry J. Gramling, M. D., Milwaukee"

It was moved by Bowen–Clark that the Auditing Committee's report be accepted, with a vote of thanks to the committee for its work. Carried unanimously.

10. Problems of the State Board of Medical Examiners

Following a custom established in 1941, members of the State Board of Medical Examiners were guests of the Council at this meeting, so that mutual problems could be discussed. Secretary Crownhart explained the subject matter briefly, and called upon Dr. H. H. Christofferson, president of the Board, to present problems with which the Board is confronted. Among subjects discussed were various problems involved in the writing of examinations by applicants for license, the Medical Practice Act, and its administration during this period of national emergency.

General discussion followed, participated in by Drs. Arveson, Gramling, Allen, Clark, Butler and Gavin, and Secretary Crownhart.

11. Special Council Committee

Dr. R. W. Blumenthal, as chairman of a special Council committee on the subject of insurance, presented the report of the activities of his committee over the last year. Without discussion it was moved by Jegi–Gramling and carried, that the report be accepted.

12. Executive Sessions of House of Delegates

Secretary Crownhart presented the matter of custom that sessions of the House be executive sessions. It was moved by Blumenthal–Lambert, and carried unanimously, that it be the recommendation of the Council to the House that all sessions of the House of Delegates be executive sessions.

13. Annual Reports by Councilors as to their Respective Districts

Secretary Crownhart brought to the attention of the Council, the provision of the By-laws requiring each councilor to report at the annual meeting of the Council covering current conditions in the various districts.

14. Adjournment

After announcements by the secretary and Chairman Gavin, the meeting adjourned at 4:00 p. m.

C. H. CROWNHART
Secretary

Approved:
S. E. GAVIN
Chairman of the Council

News of the Neighbors

Indiana Doctors Open Business Office

"The physicians and dentists of Greenfield, (population 5,000) have organized a Physicians and Dentists Business Association and have opened a downtown office where all business details of the members will be handled by a lay secretary. All bookkeeping details will be handled in this office, and payment of professional fees will be handled there as well. Several doctors and dentists from this community are now in service, and those at home found it a task to look after their business affairs as well as those of a professional nature, hence this move was planned. It will be interesting to learn just how successful the venture will prove."

Minnesota Raises Dues

Contemplating that approximately one-third of the active members of the Minnesota State Medical Association and component societies will be in service by next year, delegates to the annual meeting of the Association were confronted with the question of whether to curtail activities, make deep inroads into its reserve fund, or increase dues. The ultimate decision was to increase dues $5. In commenting on this decision, the October issue of *Minnesota Medicine* remarks that this action amounts "to sharing the dues of members in service. That is the least we stay-at-homes can do for our confreres in service, even if our practices may not show some increase because of the thinned ranks at home.

"It is well for state associations and county societies to keep the home fires burning and not to reduce essential activities nor to run behind financially with the intention of making up deficits when the boys come home."

Ohio Streamlines Annual Meeting

At a meeting of the Council of the Ohio State Medical Association, it was decided to streamline the 1943 annual meeting. The policy adopted is, in part, as follows: ". . . that a business session of the House of Delegates be arranged for late afternoon or evening and that on the following day a General Session program be arranged consisting of selected subjects pertaining to the care of the civilian population and the problems of industrial health under wartime conditions; . . . that neither technical nor scientific exhibits be held at the 1943 meeting.

Ohio Adopts Statement to Aid Physicians in Service

The October issue of *The Ohio State Medical Journal* carried an insert card which read as follows:

Our Obligation

"Perhaps the physician who has been providing you with medical services is one of the many Ohio physicians now on duty with the Army and Navy.

"While he is making this sacrifice for you and me, you may count on those of us who remain on the home front to do our utmost to meet your medical needs.

"However, it is my sincere hope that when your doctor returns, you will resume your former relationship with him.

_____, M. D."

The Council of the Ohio State Medical Association recommended that each physician sign this card and display it in a prominent place in his office.

Inter-State Postgraduate Association Meets

Dr. Arthur G. Sullivan, Madison, managing director of the Inter-State Postgraduate Association of North America, reported of the association's international medical assembly in Chicago October 26 to 30.

Wartime is not the time to abandon medical meetings, Dr. Sullivan said. Doctors not called into the armed services have a heavier burden to carry, and it can easily be seen "why the medical profession must get together now more than ever to marshal its forces."

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. E. S. Schmidt, Green Bay, President
Mrs. O. M. Layton, Fond du Lac, President-Elect
Mrs. R. B. Dryer, Poynette, Vice-President
Mrs. R. M. Kurten, Racine, Recording Secretary
Mrs. L. D. Quigley, Green Bay, Corresponding Secretary
Mrs. Charles Fidler, Milwaukee, Treasurer
Mrs. C. D. Partridge, Cudahy, Parliamentarian

COMMITTEE CHAIRMEN

Archives—
Mrs. J. P. Connell, Fond du Lac

Finance—
Mrs. J. R. Minahan, Wauwatosa

Hygeia—
Mrs. A. C. Taylor, Appleton

Organization—
Mrs. O. W. Friske, Beloit

Philanthropic—
Mrs. S. O. Lund, Cumberland

Press and Publicity—
Mrs. D. B. Dana, Kewaunee

Program—
Mrs. D. F. Gosin, Green Bay

Public Relations—
Mrs. R. D. Champney, Milwaukee

Legislation (special committee)—
Mrs. L. V. Sprague, Madison

Circulation of Bulletin (special committee)—
Mrs. W. A. Wagner, Oshkosh

Fond du Lac

Committees for the year were appointed at the meeting of the Woman's Auxiliary to the Fond du Lac Medical Society held at the Hotel Retlaw on September 24. Following a 6:30 dinner, the following committee chairmen were announced, all of whom are from Fond du Lac, unless otherwise indicated:

Program—Mmes. S. E. Gavin, chairman; J. E. Twohig, T. A. Hardgrove

Social—Mrs. E. V. Smith, Jr., chairman

Philanthropic—Mmes. C. W. Leonard, chairman; J. J. Sharpe, P. G. McCabe, L. J. Simon

Hygeia—Mmes. J. S. Huebner, chairman; H. H. Hull, Brandon; C. P. Reslock, Waupun.

Public Relations—Mmes. J. P. Connell, chairman, J. M. Johnson, Ripon; W. H. Folsom

Membership—Mmes. J. C. Devine, chairman; S. A. Theisen, R. G. Raymond, Brownsville

Press and Publicity—Mrs. H. R. Sharpe, chairman

Archives—Mrs. L. C. Gardner, chairman

It was announced that the state president of the Woman's Auxiliary, Mrs. E. S. Schmidt of Green Bay, would speak at the October 29 meeting.

Kenosha

Dr. P. E. Pifer, president of the Kenosha County Medical Society, spoke to members of the woman's auxiliary on "Excerpts of Legendary Medicine" at a meeting held at the home of Mrs. C. F. Ulrich on October 6.

In his interesting talk Dr. Pifer reviewed the high lights of the history of medicine and discussed the superstitions and practices that marked its early stages. When the art of healing became separated from magic and the supernatural, Dr. Pifer said, the first milestone in the history of medicine was passed.

During the business meeting the members decided to work on surgical dressings for the Red Cross each Thursday afternoon. Mrs. Alexander Schlapik, chairman of the USO committee, announced that the group would send meat or fowl to the canteen each month.

Mrs. F. E. Andre, Mrs. G. C. Schulte, Mrs. W. C. Kleinpell, and Mrs. E. F. Andre were the assisting hostesses for the social hour which followed the meeting. Mrs. L. H. Lokvam and Mrs. A. M. Rauch poured.

New officers and committee chairmen of the Kenosha County Auxiliary, all of whom are from Kenosha, are:

Officers

President—Mrs. A. M. Rauch
President-elect—Mrs. C. M. Creswell
Secretary—Miss Norabelle Binnie
Treasurer—Mrs. J. P. Graves

Committee Chairmen

Hygeia—Mrs. L. T. Kent
Program—Mrs. L. H. Lokvam
Public Relations—Mmes. L. M. Rauen, C. E. Pechous
Philanthropy—Mmes. G. C. Schulte, C. G. Richards
Publicity—Mmes. W. C. Kleinpell, E. F. Andre
Ways and Means—Mrs. Alexander Schlapik
Membership—Mmes. C. F. Ulrich, C. C. Davin
Archives—Mrs. A. L. Mayfield
Hospitality—Mrs. E. F. Andre
Telephone—Mmes. A. J. Randall, H. M. Ripley, J. W. Holm, Herbert Robinson

Milwaukee

The Woman's Auxiliary to the Medical Society of Milwaukee County held its first meeting of the fall season on October 9 at the Pfister Hotel. Forty members were present to greet the incoming president, Mrs. H. O. Zurheide, and other new officers.

During the program the Reverend Lee J. Ferry spoke on "Associated Charities," and Mr. Richard Rice discussed "Civilian Defense," stressing the need for nurses' aides. Members also enjoyed several violin solos by Mrs. Benjamin Lieberman and dramatic readings by Miss Inez Shabart.

It was announced by Mrs. Zurheide that at a recent board meeting approval was voted to further

the educational campaign of the Women's Field Army for the Control of Cancer.

The meeting was followed by a tea. Mrs. E. L. Everts, as chairman of the social committee, was in charge of arrangements, and she was assisted by Mrs. D. D. Frawley and Mrs. E. F. Guy. Mmes. H. J. Heeb, E. J. Carey, R. G. Washburn, and E. F. Barta presided at the tea tables.

The following new officers were honored:

President-elect—Mrs. F. R. Janney, Wauwatosa
Vice-president—Mrs. R. H. Frederick, West Allis
Corresponding Secretary—Mrs. D. E. W. Wenstrand
Recording Secretary—Mrs. E. J. Behnke
Treasurer—Mrs. E. P. Bickler
Parliamentarian—Mrs. R. E. Fitzgerald
Board members—Mmes. T. S. O'Malley, Irwin Schulz, S. J. Silbar, E. F. Barta, R. D. Champney, W. A. Ryan, T. H. Rolfs

Racine

Mrs. R. D. Jamieson, retiring president of the Racine County Medical Auxiliary, was hostess to twenty-five members of that group on Monday afternoon, October 12. Roses and baby mums formed a centerpiece for the tea table, at which Mrs. R. M. Kurten and Mrs. C. O. Schaefer poured. A bouquet of red roses was presented to Mrs. Jamieson in appreciation of her work for the auxiliary, and members enjoyed several piano selections played by Miss Ruth Jamieson.

New officers of the Racine County Auxiliary are:

President—Mrs. R. M. Kurten
President-elect—Mrs. H. G. Brehm
Vice-president—Mrs. F. C. Christensen
Secretary—Mrs. C. L. Kline
Treasurer—Mrs. C. F. Browne

Mrs. Kurten, the new president, is also recording secretary for the state auxiliary.

Rock

Sixteen members of the Woman's Auxiliary to the Rock County Medical Society met at the Hotel Hilton on September 22 for their monthly business meeting.

Reports of the state convention in Milwaukee were given by Mmes. H. E. Kasten, Beloit, T. J. Snodgrass, R. C. Hartman, W. T. Clark, and C. R. Gilbertsen, all of Janesville.

Mrs. Gilbertsen, president of the auxiliary, appointed Mmes. Hartman, Kasten, and C. E. Smith of Beloit to make up the nominating committee. Officers will be elected at the October meeting.

Sauk

Members of the Woman's Auxiliary to the Sauk County Medical Society met for dinner at the Warren Hotel in Baraboo on September 30. Following the dinner, the first fall business meeting was held at the Elks Club.

Mrs. J. F. Moon, Baraboo, was appointed press and publicity chairman for the year, and Mrs. C. R. Pearson, Baraboo, gave a short report on the state convention in Milwaukee. Several matters were discussed, among them the disposal of remaining layettes, and it was decided that the project of making surgical dressings would be continued for several meetings.

A former secretary-treasurer, Mrs. E. V. Stadel, Reedsburg, has obtained a leave of absence for the duration, and will accompany her husband to his post in the armed forces.

Washington—Ozaukee

Nineteen members and guests of the Woman's Auxiliary to the Washington-Ozaukee County Medical Society met on September 10 at the Ozaukee Country Club, where a luncheon-bridge had been arranged by Mrs. O. J. Hurth, Cedarburg. Guests included Mrs. Robert Radtke, Watertown; Mrs. J. Eichman, Allenton; Mrs. W. T. Becker and Mrs. V. A. Waldren, Cedarburg, and Miss Elizabeth Carthaus, Thiensville.

News of interest from the twentieth anniversary meeting of the national auxiliary at Atlantic City in June, as reported in *The Bulletin* was reviewed by Mrs. A. H. Barr, Port Washington. This is the first time in many years that there were no local delegates to the national convention.

The following new officers were installed:

President—Mrs. J. E. Reichert, West Bend
President-elect—Mrs. P. B. Blanchard, Cedarburg
Secretary-Treasurer—Mrs. K. T. Bauer, West Bend

The October meeting of the Washington-Ozaukee Auxiliary was held at the Mayer Hotel in Port Washington on October 8. Following a one o'clock luncheon, the business meeting was held at the home of Mrs. C. C. Stein, after which bridge was played.

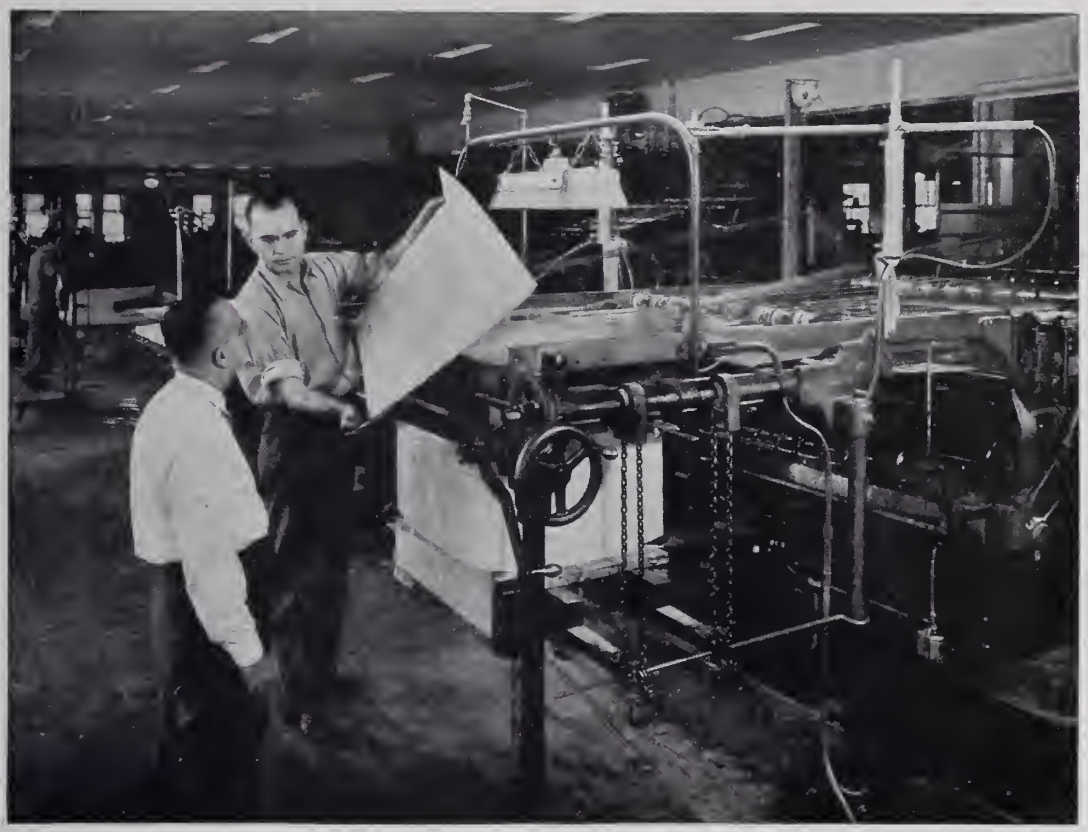
Waukesha

When the members of the Auxiliary to the Waukesha County Medical Society met at the home of their president, Mrs. T. H. Nammacher, Oconomowoc, on October 7, a considerable portion of their time was given over to an annual business meeting.

Minutes of the June meeting were read and approved, and Mrs. K. W. Doege, Oconomowoc, gave a report on the state convention. Members then heard yearly reports of the various committee chairmen, and were particularly interested in the scrapbook, which was compiled by Mrs. W. T. Murphy, Waukesha, archives chairman.

Mrs. P. B. Theobald, Oconomowoc, chairman of the program committee, and Mrs. G. W. Brewer, Hartland, chairman of *Hygeia*, are now numbered with the "Service Wives" from the Waukesha County Auxiliary and were not present to give their reports. A letter from Mrs. J. C. Frick, Waukesha, asking for a similar leave of absence, was read.

The annual election of officers resulted as follows:



THE ART OF DOING THINGS WELL

THERE is one department in the Lilly organization where no one knows much about drugs, where there are no machines for making pills or tablets, and where not a piece of chemical apparatus can be found. This is the printing plant for Lilly labels, Lilly literature, and one of the biggest jobs of all—the *Physician's Bulletin*. Here information from the scientific staff is prepared for distribution in both Americas and as far away as South Africa—information for medical men, the allied professions, and no others.

ETHICAL PRODUCTS OF RESEARCH
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PRINCIPAL OFFICES AND LABORATORIES, INDIANAPOLIS, INDIANA, U.S.A.

President—Mrs. E. L. Lochen, Waukesha
President-elect—Mrs. J. C. Hassall, Oconomowoc
Vice-president—Mrs. K. W. Doege, Oconomowoc
Corresponding Secretary—Mrs. H. F. I. Sydow, Waukesha
Recording Secretary—Mrs. F. W. Aplin, Waukesha
Treasurer—Mrs. D. C. Wilkinson, Oconomowoc

After a discussion of matters of policy and program for the year, the business meeting was adjourned and a buffet supper was served by Mrs. Nammacher, the former president, with Mmes. K. W. Doege, A. J. Loughnan, and J. S. Giffin, all of Oconomowoc, as assisting hostesses. Moving pictures of gardens and of activities at the Wisconsin Home and Farm School were then shown by Mrs. Loughnan.

Society Proceedings

Brown—Kewaunee—Door

The Brown–Kewaunee–Door County Medical Society held a dinner and business meeting at the Beaumont Hotel in Green Bay on October 15. Walter Zeit, Ph. D., assistant professor of anatomy at the Marquette University School of Medicine, Milwaukee, gave an illustrated talk on "Anatomy of the Female Pelvis."

Columbia—Marquette—Adams

Nine members of the Columbia–Marquette–Adams County Medical Society assembled at St. Savior's General Hospital, Portage, on October 20, at 8:00 p.m. for a business meeting.

Dr. Louis V. McNamara of Montello assumed the office of president, and the society voted to purchase $300 in war bonds.

Dane

Sister Elizabeth Kenny explained her treatment of acute anterior poliomyelitis to the Dane County Medical Society, the staff of the University of Wisconsin Medical School, and medical students on October 15 at the Service Memorial Institute, Madison.

Fond du Lac

Dr. Robert E. Fitzgerald, Milwaukee, spoke on "Procurement and Assignment" before a meeting of the Fond du Lac County Medical Society on September 24 at the Retlaw Hotel in Fond du Lac.

Green Lake—Waushara

A meeting of the Green Lake–Waushara County Medical Society was held on October 15 at 6:30 p. m. at the Hotel Whiting, Berlin. Nine members and ten guests were present.

Dr. Elmer L. Sevringhaus and Dr. John E. Gonce, both of Madison, spoke on "Handling of Diabetes by the General Practitioner" and "Tetanus Toxoid" respectively.

Jefferson

The first meeting of the Jefferson County Medical Society for the new season was held on Thursday night, October 15, at the Carlton Hotel, Watertown. Nearly the full membership was present for the regular dinner and to hear an address by Dr. Edward Ochsner of Chicago, who spoke on "The Physician's Influence in the Directing and Guiding of the Lives of His Patients."

Dr. T. L. Harrington, Milwaukee, also discussed the subject of "Tuberculosis Control."

La Crosse

At a meeting of the La Crosse County Medical Society on September 8, the following officers, all of La Crosse, were elected to take office as of January, 1943:

President—Dr. Archie A. Skemp
Vice-President—Dr. Paul C. Gatterdam
Secretary–Treasurer—Dr. Jens A. Rosholt
Delegate—Dr. F. A. Douglas
Alternate-Delegate—Dr. Jens A. Rosholt
Board of Censors—Drs. James E. McLoone, Robert L. Eagan, Herman E. Wolf

A motion was made and carried to invite the medical officers now stationed at Camp McCoy to the regular county society meetings each month.

Langlade

Officers for the new year were elected at a meeting of the Langlade County Medical Society on October 21. The following Antigo physicians will serve during the coming year:

President—Edwin G. Bloor
Secretary–Treasurer—Carl E. Zellmer
Delegate—Carl E. Zellmer
Alternate Delegate—William P. Curran

Manitowoc

At a dinner meeting in Manitowoc on October 3, the Manitowoc County Medical Society elected the following officers for the coming year:

President—Dr. Francis E. Turgasen, Manitowoc
Vice-President—Dr. Leon D. Sobush, Manitowoc
Secretary–Treasurer—Dr. Walter H. Scherping, Manitowoc
Censor—Dr. John M. Kelley, Cato
Delegate—Dr. Erwin C. Cary, Reedsville
Alternate-Delegate—Dr. T. H. Rees, Manitowoc

Commando raids are dramatic and do their share in helping us win the war. Less spectacular, but equally important to Victory, is the role of nutrition in building a strong hard-hitting America.

COCOMALT, the enriched food drink, is doing its part in the all-out effort toward better states of nutrition. For, COCOMALT contains vitamins A, B_1, D and the minerals calcium, phosphorus and iron . . . all essential factors in well-balanced diets.

More and more physicians are recommending this delicious food drink for the entire family. The rich, full flavor of COCOMALT, either hot or cold in milk, is a delightful drink for those who will not ordinarily drink milk alone.

Cocomalt

ENRICHED FOOD DRINK

R. B. DAVIS COMPANY, Hoboken, N. J.

Milwaukee

At a meeting of the Medical Society of Milwaukee County on October 9, Dr. Robert E. McDonald, Milwaukee, spoke on "Premature Milk Station." The guest speaker was Carl G. Hartman, Ph. D., from the Department of Zoology, University of Illinois, who spoke on "Ovulation: physiology and experimental control."

Outagamie

The Outagamie County Medical Society held its opening meeting of the season on September 26 at the Riverview Country Club. Dr. Edward F. Mielke, Appleton, was the speaker of the evening. His subject was "Inaccuracy of Pelvic Examination."

The October meeting of the Outagamie County Medical Society was held at 6:30 o'clock on Thursday evening, October 29, at the Conway Hotel, Appleton. Dr. Oscar A. Sander, Milwaukee, addressed the group on "Tuberculosis and Silicosis."

Polk

Dr. James F. Shandorf, instructor of obstetrics at the Minneapolis General Hospital and the Minnesota General Hospital, spoke on "Breech Deliveries" at a meeting of the Polk County Medical Society in Amery on September 17.

Racine

The Racine County Medical Society held a dinner meeting on October 15 in honor of Dr. Russell M. Kurten, president-elect of the State Medical Society of Wisconsin.

Rock

A 6:30 dinner meeting of the Rock County Medical Society was held on October 27 at the Rock County Hospital, Janesville. Members of the society were guests of Superintendent and Mrs. A. H. Cullen and the trustees.

Dr. Thomas J. Snodgrass, Janesville, was the program chairman. Dr. Theodore C. Erickson, professor of neural surgery at the University of Wisconsin, Madison, spoke on "The Diagnosis of Epilepsy."

Sheboygan

Twenty members of the Sheboygan County Medical Society assembled at 8:15 p. m., October 8, at St. Nicholas Hospital, Sheboygan, to see the movie entitled "Sex Hormones, Physiology, Diagnosis and Therapy" presented by Mr. Anderson of Parke, Davis & Company.

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met at the Eagles Hotel, Fountain City, on October 15. Eleven members were present. Dr. James C. Fox of La Crosse addressed the group on "The Diagnosis and Treatment of Pneumonia, particularly the virus type."

Winnebago

The Winnebago County Medical Society held its first regular monthly meeting of the fall season at the Hotel Menasha, Menasha, on October 1. Dinner was served at 6:30 p. m. Dr. Robert C. Brown, Green Bay, addressed the group on "Differential Diagnosis of Low Back Pain." Thirty members were present.

First Councilor District

The annual meeting of the First Councilor District was held at Hotel Rogers, Beaver Dam, on Sunday, September 27, with wives and friends of members attending as guests.

Dr. William A. Mowry, Madison, addressed the group on "Common Allergies," and Dr. Morris W. Sherwood, Milwaukee, spoke on "Automobile Accidents."

At the business meeting, the following physicians were elected as officers for the coming year:

President—Dr. Richard E. Davies, Waukesha
Vice-President—Dr. Joseph B. Noble, Waukesha
Secretary–Treasurer—Dr. Frederic J. Woodhead, Waukesha

Tenth Councilor District

The Forty-second Annual Meeting of the Tenth Councilor District was held on Thursday, September 24, at Luther Hospital, Eau Claire. A session on neuro-surgery and fractures was held in the morning with Drs. Theodore C. Erickson, Madison, and Harry B. Macey, Rochester, Minnesota, as speakers. This session was followed by a medical and pediatric clinic, at which Drs. Erling S. Platou and Wesley W. Spink, both of Minneapolis, were speakers.

Luncheon was served at 1:00 p. m. and was followed by additional discussion groups on infant feeding, fractures, diagnosis and treatment of epilepsy, and special problems concerning the diagnosis and treatment of acute respiratory infection.

In the evening a dinner and smoker were held at the Eau Claire Country Club at 6:30. Dr. G. W. Beebe, Eau Claire, was elected president of the group, and Dr. C. N. B. Hatleberg, Chippewa Falls, was re-elected secretary.

SOCIETY RECORDS

New Members

S. F. Martin, Viroqua.
Milton H. Uhley, Milwaukee.
O. F. Foseid, Neenah.
A. S. Horn, Rib Lake.

Announcing

A SUPPLEMENTAL ALUMINUM THERAPY

Aluminum hydroxide gel is accepted therapy in the management of peptic ulcer. Its impressive record of effectiveness suggested the development of an alternate aluminum preparation to meet particular requirements in certain cases.

Phosphaljel,* Wyeth's Aluminum Phosphate Gel, was originated by Wyeth and was used experimentally in the first successful attempt to prevent postoperative jejunal ulcer in Mann-Williamson dogs. Some animals were allowed to develop Mann-Williamson ulcers and the effectiveness of Phosphaljel was further demonstrated when its administration was followed by prompt healing of these lesions in every case.[1]

In man, Phosphaljel was found to be most effective in peptic ulcer following gastrojejunostomy, a condition which appears to be analogous to the Mann-Williamson ulcer in dogs.[1]

Phosphaljel contains 4% aluminum phosphate and possesses antacid, astringent and demulcent properties analogous to those of aluminum hydroxide gel.

[1]*Fauley, G. B.; Freeman, S.; Ivy, A. C.; Atkinson, A. J., and Wigodsky, H. S.: Aluminum Phosphate in the Therapy of Peptic Ulcer, Arch. Int. Med. 67: 563-578 (March) 1941.* *Reg. U. S. Pat. Off.

JOHN WYETH & BROTHER, INCORPORATED, PHILADELPHIA

Changes in Address

Esther C. Kurtz, Milwaukee, to 2108 Kendall Avenue, Madison.

A. L. Martin, Ashland, to % Children's Hospital, Nineteenth at Downing, Denver, Colorado.

J. W. Rock, Thiensville, to Veterans Administration, Bay Pines, Florida.

S. M. Welsh, La Crosse to 270 West Broadway, Waukesha.

E. S. Sinaiko, Markesan to Walnut Park Plaza, Walnut and Sixty-third Streets, Philadelphia, Pennsylvania.

W. H. Jaeschke, Fond du Lac, to Wisconsin General Hospital, Madison.

J. G. Russo, Statesan, to Lake View Sanatorium, Madison.

C. O. Rogne, Ettrick, to 1338 Main Street, Dubuque, Iowa.

BIRTHS

A son to Dr. and Mrs. W. J. Mauermann, Madison, on October 11.

A daughter, Bonnie Jayne, to Dr. and Mrs. J. F. Gallagher, Madison, on October 17.

A daughter, Suzanne, to Dr. and Mrs. V. F. Lang, Milwaukee, on September 24.

A daughter to Dr. and Mrs. W. P. Curran, Antigo, on October 15.

A daughter, Kristine, to Dr. and Mrs. Manfred Landsberg, Cudahy, on October 4.

A son to Dr. and Mrs. R. M. Wheeler, Madison, on October 14.

A daughter to Dr. and Mrs. S. Sorkin, Evansville, on September 25.

A daughter, Suzanne, to Captain and Mrs. L. M. Boxer, Milwaukee, on September 24.

DEATHS

Dr. Hans C. Ericksen, 57, died at his home at Soldiers Grove on September 18. He was born in Sondreland, Norway, in 1885 and attended the University of Minnesota before starting his practice at Stanley thirty years ago.

Later he moved to Viroqua where he practiced for twelve years and subsequently spent eight years at various places in North Dakota. Dr. Ericksen was also physician at CCC camps in Oregon and California. He had been located at Soldiers Grove for the last year.

Dr. Ericksen was awarded the distinguished service cross for medical work and bravery as a captain in the 32nd Division, 127th Infantry, in World War I.

He is survived by his widow, a daughter and a son.

Dr. Maxillian A. Bussewitz, 75, died on September 20 at St. Mary's Hospital, Milwaukee, after an illness of several months.

He was born in Prussia in 1867 and came to Milwaukee in 1880 where he later attended Milwaukee State Normal School. He was graduated from Ripon College and received his master's degree from the University of Wisconsin. He obtained his medical education at the Wisconsin College of Physicians and Surgeons, Milwaukee, from where he was graduated in 1907.

From 1907 until he became ill in February, Dr. Bussewitz was a professor of physiology at the Marquette University School of Medicine. His practice was limited to health work among the students and occasional emergency calls from neighbors.

Dr. Bussewitz was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association. He was a lieutenant colonel in the medical officers' reserve corps.

Surviving are his widow and two daughters.

Dr. Walter G. Sexton, 56, Marshfield physician, died at a Rochester, Minnesota, hospital on September 27, following a two weeks' illness.

He was born in Madison in 1886 and was graduated from the University of Wisconsin in 1908. He received his medical degree from Johns Hopkins University School of Medicine in 1911, following which he took postgraduate work at Vienna.

Dr. Sexton was one of the six founders of the Marshfield Clinic. He was a member of the Wood County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, two sons and two daughters.

Dr. John Baird, 82, died on October 5 at his home in Superior following a brief illness.

He was graduated from the Medical Faculty of Trinity University, Ontario, Canada, in 1888, and practiced in Superior for fifty-three years.

Dr. Clarence C. Del Marcelle, 53, Green Bay, died at his home on October 11 following a long illness which was the result of an accident he suffered seventeen years ago.

Dr. Del Marcelle was born at Wausau in 1889 and received his preliminary education at Green Bay schools. His medical education was received at the Marquette University School of Medicine from which he was graduated in 1914. He had practiced at Neenah before World War I and for a short time thereafter, later moving to Green Bay.

Dr. Del Marcelle was a former member of the Winnebago County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Dr. John J. Laird, 65, Black Creek, died in Appleton on October 16 after an illness of a few months.

He was born in 1877 in the town of Ellington and attended Ryan High School in Appleton. After teaching two years in county schools, he attended Lawrence College for one year and later the University of Chicago. In 1904 he was graduated from Rush Medical College.

Dr. Laird was a member of the Outagamie County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow and three sons, one of whom is Dr. J. W. Laird of Appleton.

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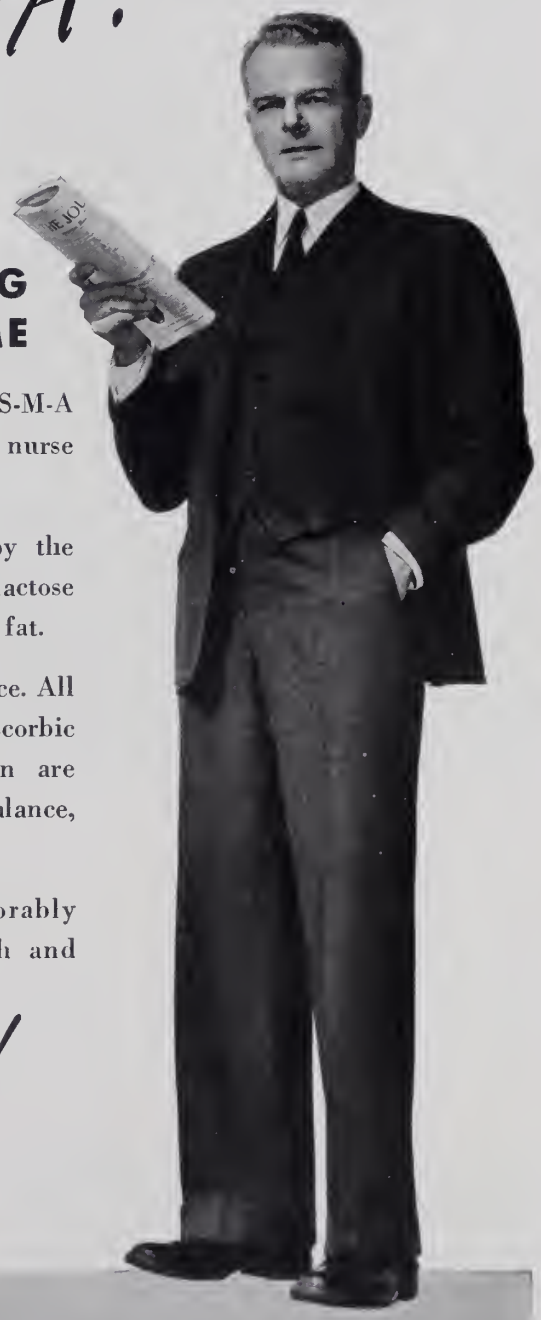

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Coming Events

American College of Surgeons

The annual Clinical Congress of the American College of Surgeons, which was scheduled to be held in Cleveland November 17–20, 1942, was cancelled by the Board of Regents of the College at a meeting held in Chicago October 14. Motivated primarily by patriotism, the Regents were influenced by the present conditions surrouding the general war program which have led to a greater burden on the members of the surgical profession in their local communities as a result of the large proportion of the profession which is serving with the armed forces.

American Board of Obstetrics and Gynecology

The next written examination and review of case histories (Part I) for all candidates will be held in various cities of the United States and Canada on Saturday, February 13, 1943, at 2:00 p.m.

Arrangements will be made so far as possible for candidates in military service to take the Part I examination at their places of duty.

All candidates will be required to take both the Part I examination and the Part II examination (oral-clinical and pathologic examination). Candidates who successfully complete the Part I examination proceed automatically to the Part II examination which will be held in Pittsburgh, Pennsylvania, beginning Wednesday, May 19, and closing Tuesday, May 25, 1943.

Applications for this year's examinations must be in the office of the secretary not later than November 16, 1942.

For further information and application blanks, address Dr. Paul Titus, secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

The National Foundation For Infantile Paralysis

The third annual meeting of the National Foundation for Infantile Paralysis will be held in New York City on December 3–4 inclusive.

Wisconsin General Hospital Staff Meetings For 1942–43

These meetings are held in the Auditorium of the Service Memorial Institute. Attendance is restricted to third and fourth year medical students, internes, residents, hospital and medical school faculty, and interested outside physicians.

November 17—Dr. T. C. Erickson: Head Injuries
December 1—Dr. F. A. Davis: Common Pathologic Conditions of the Fundus of the Eye
December 15—Dr. W. M. Nesbit: Common Office Procedure in the Practice of Ear, Nose, and Throat
January 5—Dr. C. M. Kurtz: Cardiac Problems for the General Practitioner
January 19—Dr. W. H. Oatway and associates: Symposium on Tuberculosis
January 26—Dr. R. E. Burns: Backache
February 2—Dr. E. L. Sevringhaus: The Rudiments of Managing Diabetes and Obesity
February 16—Dr. L. W. Paul: Fundamentals of Gastro-Intestinal X-ray Diagnosis
February 23—Dr. E. R. Schmidt: Problems of Abdominal Surgery
March 2—Dr. I. R. Sisk: The Etiology and Treatment of Renal and Ureteral Stones
March 16—Dr. J. E. Gonce: Some Aspects of Urinary Infection in Infancy and Childhood
March 23—Dr. C. S. Harper: Office Gynecology
April 6—Dr. R. E. Campbell: Carcinoma of the Uterus
April 20—Dr. K. L. Puestow: Sigmoidoscopic and Radiologic Correlation in Diagnosis and Treatment of Colonic Disorders
April 27—Dr. O. O. Meyer: Peripheral Vascular Disease
May 4—Dr. E. A. Pohle: Indications and Contraindications for Roentgen Therapy

Milwaukee Children's Hospital Clinical Presentations

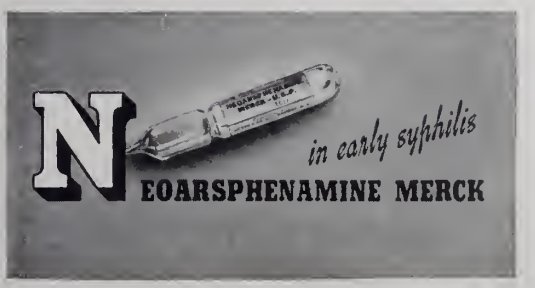
The staff of the Milwaukee Children's Hospital has arranged a schedule of clinical presentations for the coming fall and winter months. The time of the clinical presentations will be from 12:30 to 1:30 p. m. Dr. Arthur A. Schaefer will direct the surgical clinics, Dr. Walter P. Blount will direct the orthopaedic clinics, and Dr. A. L. Kastner will direct the pediatric clinics.

November 13—Pediatric Clinic
November 16—Surgical Clinic
November 17—Orthopaedic Clinic
November 20—Clinicopathologic Conference
November 23—Surgical Clinic
November 24—Orthopaedic Clinic
November 27—Pediatric Clinic
November 30—Surgical Clinic
December 1—Orthopaedic Clinic
December 4—Pediatric Clinic, Discussion of Epilepsy in Children from a Neurosurgeon's Viewpoint. T. C. Erickson, M. D., Madison
December 7—Surgical Clinic
December 8—Orthopaedic Clinic
December 11—Pediatric Clinic
December 14—Surgical Clinic
December 15—Orthopaedic Clinic
December 18—Clinicopathologic Conference

PRICE OF NURSERY RHYME BOOKLETS MISQUOTED

In the October issue of *The Journal* a description was given of the nursery rhyme booklets available through the office of the State Medical Society. The charge for these pamphlets, based on large quantity printer's cost, should have read $1.15 for 100 copies; fifty copies for 60 cents.

As a result of the discovery of the effectiveness of arsenotherapy in the treatment of syphilis, the "shadow on the land" now may be appreciably reduced. . . . In no small measure, the large-scale production of Neoarsphenamine Merck and Tryparsamide Merck, is contributing to the alleviation of human suffering caused by this venereal infection.



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THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

A Textbook of Surgery. By American authors. Edited by Frederick Christopher, B.S., M.D., F.A.C.S., associate professor of surgery, Northwestern University Medical School, chief surgeon, Evanston (Illinois) Hospital. Ed. 3, completely revised and reset. Cloth. Price $10. Pp. 1764, with 1538 illustrations on 771 figures. Philadelphia: W. B. Saunders Company, 1942.

The third edition of Christopher's "A Textbook of Surgery" should find its way into every doctor's office. It covers the subject of surgery in sufficiently detailed manner to be of definite use to the practitioner in regard to diagnosis, symptomatology, prognosis and general principles of treatment. The exact technic of surgery is not discussed, since that belongs to the realm of surgical specialty. The additions made in orthopedic surgery, shock, fluid balance and thoracic surgery are excellent. As stated above, the reviewer thinks this is an excellent book for the practicing physician and surgeon but is much too long and detailed for medical students. A. R. C.

The Modern Attack on Tuberculosis. By Henry D. Chadwick, M. D., superintendent of Westfield State Sanatorium, 1909–1929; tuberculosis controller of the City of Detroit, 1929–1933; commissioner of public health of the Commonwealth of Massachusetts, 1933–1938; medical director of Middlesex Tuberculosis Sanatorium, 1938–1941, and Alton S. Pope, M. D., chief of the Bureau of Communicable Diseases, Department of Health, Chicago, 1926–1929; deputy commissioner of public health and director of the Division of Tuberculosis, Commonwealth of Massachusetts. Cloth. Price, $1.00. Pp. 95. New York: The Commonwealth Fund, 1942.

This eighty-six page book covers much material which should be of interest to all of the medical profession and to all public health workers. The material is well presented, concise, and there is an adequate bibliography.

In the first chapter the essentials for a program for the eradication of tuberculosis are given: 1. A medical profession interested in the problem and aware of the methods of diagnosis and treatment; 2. Availability of methods of diagnosis to all physicians, regardless of the patient's financial status; 3. A well organized health department.

In Chapter II the epidemiologic aspects are discussed, and the significant point is made that tuberculosis is increasingly becoming a disease of older occupied men.

The third chapter is a concise discussion of the various methods of diagnosis.

The function of the sanatorium as a place to care for and isolate as well as train the tuberculous patient is dealt with in the fourth chapter. The sad commentary on the present status of early diagnosis is that only 10 to 15 per cent are admitted in the minimal stage and that 25 per cent are admitted too far advanced to be helped. This condition has existed for years, and will change only if routine chest roentgenograms are made on the supposedly well individual.

In Chapter V the case finding problem is discussed. The importance of case finding programs in the adult contacts, adults in industry, and adults on relief is pointed out.

The last chapter lays a working plan for a community campaign. The book ends with the heartening forecast that if the present rate of decline be maintained, in 2000 A. D. tuberculosis will be eradicated. If the present death rate is considered, this will mean a saving of 60,000 lives a year in the United States. H. D.

Advances in Internal Medicine, Volume I. Edited by J. Murray Steele, M. D., Welfare Hospital, New York University Division, Welfare Island, N. Y., with 7 associate editors, 10 contributors. Cloth. Price, $4.50. Pp. 292. New York: Interscience Publishers, 1942.

This is the first volume, of which others are to follow from time to time, with the aim of furnishing summarizing discussions of important fields in internal medicine in which progress has recently occurred. The subjects to be discussed are to be handled, as in this first volume, by authorities in the respective branches.

The present volume contains ten papers. The subjects discussed are: the use of the Miller–Abbott tube; the use of insulin and protamine insulin in diabetes; sympathetic nervous control of the peripheral vascular system; the sulfonamides and infections of the urinary tract; trends in the study of influenza; hypertension; nephrosis; and riboflavin deficiency. Every subject is ably handled, clearly and simply written and very informative. Some of the papers, as the first for example by Dr. Abbott, are very detailed, others rather terse. The majority seem to strike an ideal balance in furnishing a great deal of pertinent information in fifteen or twenty pages that will be of interest and use to the busy reader.

Most of the articles have a brief summary at the end of the chapter. Each of the articles is well documented with an adequate bibliography of pertinent work in the respective fields. Without exception the style of the papers excels in simplicity without submission to anything suggesting a relaxation of the strictly scientific attitude.

The reviewer knows of no other American source for the type of medical information here presented

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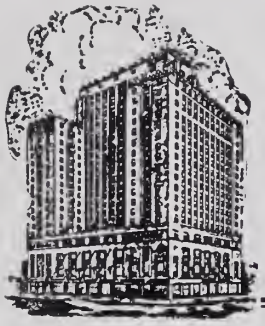

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which is as compact or on as scholarly a plane. The practitioner of medicine will find this an excellent source of new but tested information. One will look forward to future volumes, if the high standard of the first is maintained. The book is well bound, well printed on good paper and of a size that is easily handled. This work can be highly recommended to physicians seeking a means of keeping abreast of important advances in internal medicine. O. O. M.

Physical Diagnosis. By Richard C. Cabot, M. D., late professor of clinical medicine, Harvard University; late chief, West Medical Service, Massachusetts General Hospital, and F. Dennette Adams, M. D., instructor in medicine, Harvard Medical School, courses for graduates; physician, Massachusetts General Hospital. Ed. 13. Cloth. Price, $5. Pp. 888, illustrated. Baltimore: Williams & Wilkins Company, 1942.

This text was completely revised and greatly enlarged in the twelfth edition, and no such radical changes have been made in the thirteenth. However, the sections on the mouth, back, pulse, classification of heart murmurs and coronary heart disease have been reorganized. The chapter on congestive heart failure has been supplemented by a discussion of inadequate cardiac output. Dr. Paul D. White has assisted the author in the cardiac revisions. The text can be highly recommended to students and is an unusually well printed and well illustrated book of almost 900 pages for a very reasonable price. M. L. C.

Night of Flame. By Dyson Carter. Cloth. Price, $2.50. Pp. 337. New York: Reynal & Hitchcock, 1942.

It is interesting to speculate on the type of mind which thinks of doctors as men in white and hospital life as a conglomeration of intrigue, sadism, thwarted passions, and one long series of emergencies. The present volume "Night of Flame" is another of those know-the-truth or behind-the-scenes variety, its only claim to distinction being the fire which destroys the hospital and fills ninety-two of the 337 pages. Of this major catastrophe the author writes graphically and dramatically. The pyromaniac reader will lick his chops over descriptions such as:

> "The film twitched. The steam radiator beside it gurgled and clanked. Invisibly the warm metal poured out its gentle heat to the film. The molecules drank and drank and drank the energy draught. Their thirsts were insatiable. The wine of the radiant heat poured to them steadily and they quaffed, milliards of billions of heat-drunken molecules.
>
> On the surface of the film the molecules in the bacchanalian frenzy of their centrifugal dance began to fly apart. The bonds of their chemical marriages were dissolved. Wild and lusty in their release, the carbon and hydrogen atoms, divorced and free, found waiting the feverish embrace of the air, the air's oxygen. The new adulterous unions were hotly impatient.
>
> Pretty, pretty, the little dancing flames."

As to how far this book will take the reader—as the jacket claims—"behind the scenes in a great hospital" is a moot question. Those of us who are only doctors and merely work in hospitals will, in all probability, find it pretty hard to take. A. C. W.

The Medical Clinics of North America. Volume XXVI, Number 4. Symposium on Industrial Medicine. 20 contributors. Cloth. Price, $16 per year, bi-monthly publications. Pp. 348. Philadelphia: W. B. Saunders, July, 1942.

Twenty different articles by twenty different authoritative contributors are included in this volume. Each contributor has presented one phase of industrial medicine in concise outline form. Industrial medicine is presented as a special branch of medicine, with its own peculiarities and particular problems. Emphasis is placed on preventive medicine as one of the most important responsibilities of industrial physicians. Industrial medicine's important position in the current war effort is likewise emphasized.

The general content of the volume may be summarized as follows: The first three articles deal with (1) the physician's place in industry, (2) the organization and management of a working industrial medical service, (3) physical examinations in industry with emphasis on pre-employment and periodic check-up examinations.

The remaining articles deal with specific aspects of industrial medicine, including: workmen's compensation, tuberculosis (particularly as regards compensation), nutrition, industrial psychiatry, sickness among industrial workers, fatigue (particularly in relationship to the war effort), preventive, protective measures, the pneumoconiosis, lead poisoning and toxic properties of other less familiar metals. An article is also included on recent progress in aviation medicine.

The volume is so designed that it covers quite completely and concisely the field of industrial medicine. It would serve as a brief but well organized text for those interested in this branch of medicine. J. M. W.

Synopsis of Pathology. By W. A. D. Anderson, M. A., M. D., assistant professor of pathology, St. Louis University School of Medicine; pathologist, St. Mary's Group of Hospitals. Cloth. Price, $6. Pp. 661, illustrated. St. Louis: C. V. Mosby Company, 1942.

The author has quite successfully reduced an enormous mass of knowledge in the field of pathology to synopsis form. This has been accomplished with an admirable exactness and authenticity and without omission of essential details. The book is profusely and wisely illustrated.

However, it must be emphasized that the volume is a synopsis, and as such has a limited field of usefulness. It should prove valuable as an immediate quick reference or review of pathology, since a very wide range of subjects is treated. The well chosen references give a readily available means of enlarging on the outline of subjects presented. J. C. McC.

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Prof. of Bacteriology, Duke University, Durham, N. C.
Subject: "Diagnosis of Non-Tuberculous Pulmonary Disease"

MILWAUKEE SESSIONS
Monday, November 16, 1942

Marquette University
School of Medicine Auditorium

Morning Session—Student's Institute ---------- 9:00 A. M.–12 M.

Afternoon Student Session—Dr. Sabin and Dr. Smith ---------- 2:30 P. M.

Milwaukee University Club
Evening Session for Practicing Physicians ---------- 8:15 P. M.
Addresses by Dr. Sabin and Dr. Smith

MADISON SESSIONS

Tuesday, November 17, 1942

Service Memorial Institute

Afternoon Student Session—Dr. Sabin and Dr. Smith ---------- 2:30 P. M.

Evening Session for Practicing Physicians ---------- 8:15 P. M.
Addresses by Dr. Sabin and Dr. Smith

Nutritional Deficiencies. Diagnosis and Treatment. By John B. Youmans, A. B., M. S., M. D., Associate Professor of Medicine and Director of Postgraduate Instruction, Vanderbilt University Medical School, Nashville, Tennessee. Assisted by E. White Patton, M. D. Cloth. Price $5. Pp. 385, with 16 illustrations. Philadelphia: J. B. Lippincott Company, 1941.

This volume presents in concise readable style the available facts of nutrition divested in large part of the theory and speculation that often complicate the comprehension of clinical nutrition. The information provided is of immediate practical value to the practicing physician since it deals directly with the recognition and treatment of deficiency states. The author is able to rely upon a considerable amount of clinical experience, made even more significant because of his geographic location in an area of endemic nutritional deficiency disease. The book is not abundantly illustrated, but the most important lesions are shown. Nearly all the known nutritional factors of 1941 are discussed, although it is perhaps unfortunate that somewhat more extensive information is not given concerning the less well known members of the vitamin B complex, inasmuch as many physicians are anxious to know the truth about these obscure components of our diets. A volume of this type is the obvious place to turn for accurate knowledge of this sort, about which countless patients have learned to ask because of the extensive publicity given to all aspects of nutrition by the press and popular journals.

The text is not profusely documented, but there are a few references given with each chapter. Section III contains details of many laboratory diagnostic methods which have been sufficiently tested experimentally to make them of some value to routine hospital diagnostic laboratories.

Generally speaking the book can be heartily recommended as a guide to an intelligent, sane approach to clinical nutrition problems, at a time when balance is most sorely needed. E. S. G.

Female Sex Hormone Therapy. A Clinical Guide. By The Medical Research Division, Schering Corp., Bloomfield, N. J. 3 vols. Paper. Pp. 161, with 8 illustrations. Bloomfield, N. J.: The Schering Corp., 1942.

This discussion of the sex-endocrine glands is made up of three small, pocket sized volumes, fitting together into a unit. One deals with the male hormones, another with the female follicular hormone and the third with the corpus luteum hormone. The discussions are sound, and the information contained is quite complete, although presented in a brief, concise form. Chemistry of these various endocrines is discussed briefly, as well as the metabolism and endocrine interrelationships which are of clinical importance. The approach throughout is that of the clinician who is not an endocrine specialist.

Although the volumes are written and produced by the Schering Corporation, there is very little commercial contamination of the material presented. Without any appreciable antecedent experience with sex endocrinology, a clinician can be intelligently guided in the handling of routine cases in this category by means of these small volumes. They are well illustrated and provided with many cleverly devised charts to simplify otherwise complex relationships. This work can be recommended with the one reservation mentioned. E. S. G.

Dietetics for the Clinician. By the late Milton Arlanden Bridges, B. S., M. D., F. A. C. P., director of medicine, detention, Rikers Island and West Side Hospitals, New York; consulting physician, Seaview Hospital, Staten Island, New York; and Department of Education, New York University, New York; assistant professor of clinical medicine and lecturer in therapeutics and nutrition, New York Post-Graduate Medical School of Columbia University; associate attending physician and chief of diagnostic clinic, Post-Graduate Hospital, New York; fellow of the New York Academy of Medicine. Ed. 4, thoroughly revised. Cloth. Price $10. Pp. 960. Philadelphia: Lea & Febiger, 1941.

Evaluation of this volume need not be long. A textbook of clinical nutrition passing into its fourth edition provides a tacit acknowledgment of its excellence. Bridges' "Dietetics" has won for itself a position of preeminence among complete treatises in the field and may properly be considered, at present, as a final authority. No effort has been spared to bring all the hundreds of tables of food values up to date and, indeed, information about foods can often be found in this volume when it cannot be located in any other source save the original literature.

The book must be appreciated for what it is—namely, a complete reference book and for that reason is long, detailed and complete, containing in all, 960 pages. For clinicians who consider their time too valuable to delve deeply into the field, less imposing, but equally accurate and dependable monographs are available. Finally, with the field of nutrition moving as it is, this work shares the handicap of all treatises on this subject, by being outdated almost before it is off the press. However, these are trivial criticisms which may be leveled at most sci-

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entific books in actively changing fields. Consequently, Bridges' "Dietetics for the Clinician" can be recommended without reservation as a reliable reference work. E. S. G.

Synopsis of Applied Pathological Chemistry. By Jerome E. Andes, M. S., Ph. D., M. D., F. A. C. P., director of department of health and medical advisor, University of Arizona, Tucson; formerly assistant professor of pathology and clinical pathology, West Virginia Medical School; and A. G. Eaton, B. S., M. A., Ph. D., assistant professor of physiology, Louisiana State University School of Medicine, New Orleans. Cloth. Price, $4. Pp. 428, with 23 illustrations. St. Louis: The C. V. Mosby Company, 1941.

This volume contains a wealth of information for the clinical pathologist and may well be considered as almost indispensable to everyone interested in setting up a hospital laboratory for the routine clinical procedures. Not only is each procedure described in detail, but a considerable amount of physiology is included with the obvious purpose of clarifying the various factors which, under normal conditions, may bring about alterations in the components of body fluids and tissues for which analysis is desirable. Thus a good but brief background is provided for interpretation of results as they are turned over to the clinical people.

In any large hospital, arguments and misunderstandings are constantly arising between the laboratories and the clinicians because of unreasonable demands made by the latter group. These demands are based upon ignorance which might be dispelled by the dissemination of correct information about laboratory procedures, their possibilities and limitations, by means of a book such as the one under consideration in this review. For this reason, it appears justified to recommend this volume to all members of medical groups who have any responsibility for requesting or interpreting, as well as performing laboratory tests.

The present reviewer considers that it is good judgment to omit useless laboratory tests from a text of this sort. In the field of endocrinology, there are almost countless procedures of a research type, not available to routine laboratories, and not sufficiently well standardized to be widely accepted. This is true also in relation to the vitamins, although in this instance many of the methods are now becoming fairly well standardized, and to that extent they should be included. The authors of this book have happily used wise discrimination in their choice of laboratory tests in the less well established branches of medicine. E. S. G.

Your Nerves. By Arnold S. Jackson, M. D., F. A. C. S. With a chapter by The Rev. Edwin O. Kennedy. Cloth. Price, $2. Pp. 197, illustrated. Madison: Kilgore Printing Company, 1942.

It is encouraging to find a surgeon who is aware of the "functional" element in his patients. Dr. Arnold Jackson's book is a mixture of common sense, platitudes, and psychiatry. Undoubtedly it will be of value to the person whose "city fever" is the result of overindulgence in smoking, drinking, work, or bridge parties, and who merely requires to be told to stop or moderate his or her activities. A. C. W.

Ambassadors in White. The story of American tropical medicine. By Charles Morrow Wilson. Cloth. Price, $3.50. Pp. 372, illustrated. New York: Henry Holt and Company, 1942.

"Ambassadors in White" is a timely presentation of the background of a pressing medical problem, namely, tropical disease. The vital role that these diseases have played in the past in changing the course of civilization is still inadequately appreciated, and even their impact upon the present world struggle will probably not be fully realized until years after that struggle is over. However, the devastation of these great scourges has once more assumed disproportionate significance as a factor in a total war that has now circled the globe, and the control of this colossal problem may well turn out to be a critical item in the final decision.

Charles Morrow Wilson has developed the story of this phase of medicine in a delightfully readable manner revolving about the personalities and accomplishments of the actors in the drama. Although the volume is deserving of special attention from the officers and men in the armed services upon whose shoulders will fall the burden of dealing with tropical diseases in the field, the style and approach are chiefly biographic, free of difficult technical language and terminology and therefore of enormous interest to all intelligent laymen. One may be assured of a deeper understanding of the front page dispatches from the fighting fronts, by an acquaintance with this volume. It is an important contribution, which ranks with the best in medical history. E. S. G.

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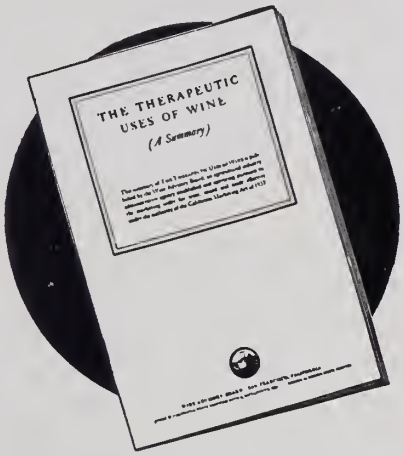

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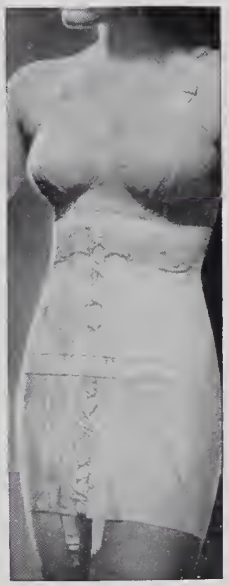

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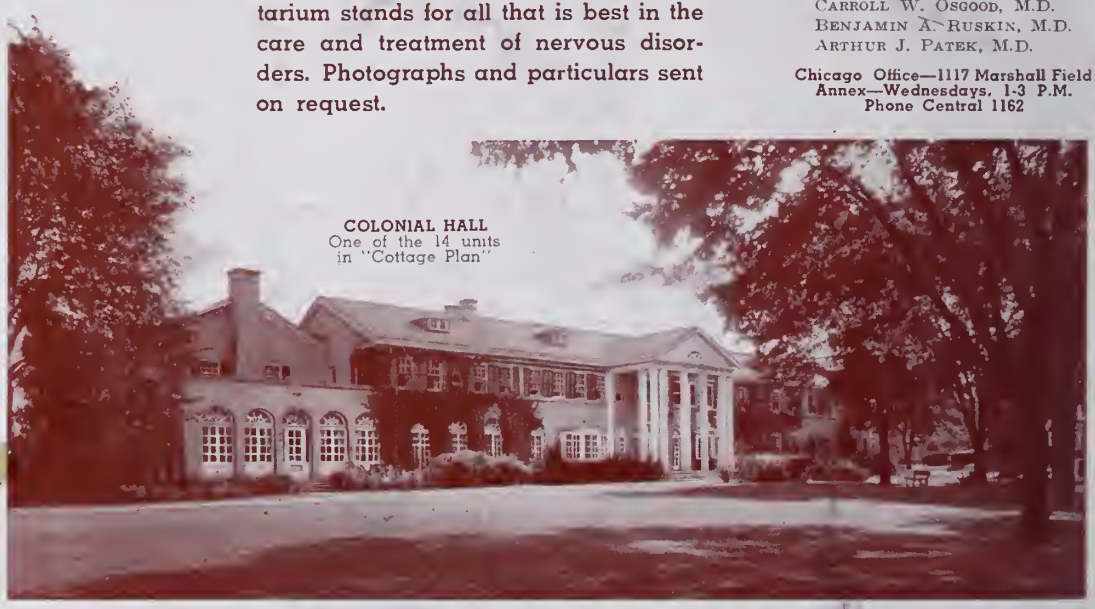

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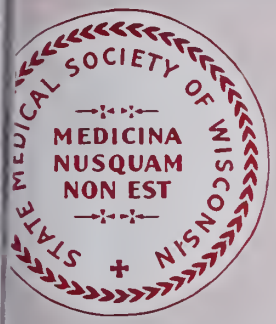

The Wisconsin Medical Journal

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By Robert I. Harris, M. B.
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[Entered as second class matter, June 30th, 1903, at the Post Office at Milwaukee, Wis., under Act of Congress March 3rd, 1879. Transferred to Madison, Aug. 1st, 1929.]
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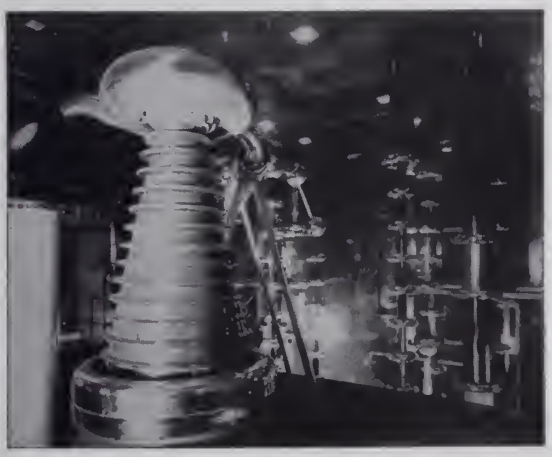

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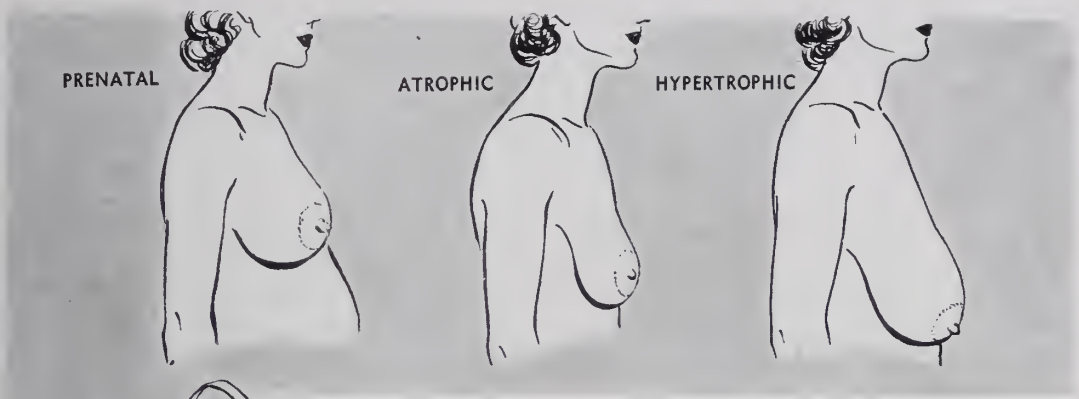

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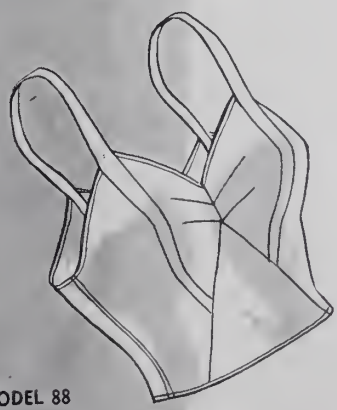

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Brückner, H.—Die Biochemie des Tabaks, 1936
The Military Surgeon, Vol. 89, No. 1, p. 5, July, 1941

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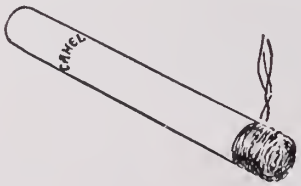

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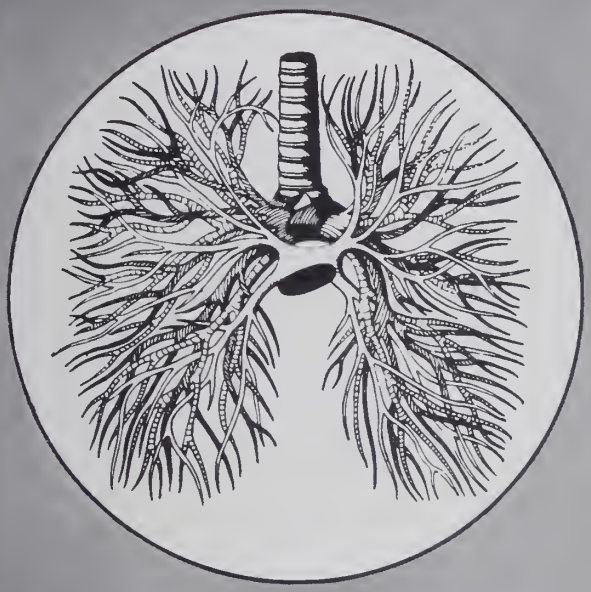

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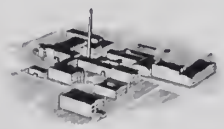

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Modern Bone Graft Surgery*

By CHESTER C. SCHNEIDER, M. D.
Milwaukee

Historical Material

ALTHOUGH some treatises on bone graft surgery appeared in foreign literature in the latter half of the nineteenth century, the first comprehensive approach to the subject was made in this country in 1915 by Dr. Fred Albee whose book, "Bone Graft Surgery," was published that year. His deep interest and remarkable mechanical skill had enabled him to develop special instruments for the performance of varied and innumerable operations of this type. The world is much indebted to him for his courage, resourcefulness, and untiring zeal in advancing this field of surgery during the last twenty-five years. While much credit is due Dr. Albee for his basic development of the art of bone graft surgery, many other surgeons, including particularly Ollier, Hibbs, Henderson, and Campbell, have made significant contributions to the field, broadening its scope and increasing its usefulness.

Principles

There are three inviolable rules in bone graft surgery: Tissues must be applied like to like, the contact must be intimate, and they must be immobilized in that position. The preservation or rapid restoration of the blood supply to the area of the graft is absolutely necessary because the graft must live as such. The promptness and durability of union and the rapidity of assimilation of the graft to the host tissues depend on close approximation of graft to host bone. Accurate and stable immobilization must be provided until secure union occurs after which the stress of maintaining immobility falls on the graft, and it grows in size and strength adapting its structure to the stress. While grafts may be secured and host bone prepared for their reception with ordinary tools, the necessity for the greatest precision in the mechanical procedures involved brings forth the advantages of automatic power-driven tools which can be adjusted to cut the graft and prepare the host bone with mathematical exactness. In addition to the certainty and precision with which power-driven tools can be used in this type of surgery, their speed of operation and the relative freedom from damaging trauma to the tissues render their use highly preferable and frequently absolutely essential to this type of surgery.

Types of Graft

The types of grafts most commonly employed are:

1. *Medullar.* These grafts (see figure 1) are generally unsatisfactory as they block the blood supply to the part and cannot be applied accurately, making vascularization of the graft uncertain. They can be used only in larger bones such as the femur, humerus and tibia, and may be broken during and immediately after the operation before external immobilization can be provided. Moreover, reaming out of marrow so damages the blood supply that in the event of failure of the medullar graft, later resort to other types of graft may likewise prove futile because of the previously induced ischemia of both ends of the bones to be united with the graft.

2. *Osteoperiosteal.* The osteoperiosteal graft of Ollier (see figure 2)—later popularized by Delageniere and Lewin—provides no mechanical continuity since it consists of soft tissue with attached plaques of bone. When

* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

Fig. 1. Roentgenograms of a very badly fractured elbow which resulted in more or less complete loss of the proximal ends of the radius and ulna, and in which an attempt to achieve ankylosis was undertaken with two heavy intramedullary grafts taken from the tibia. It will be noted that, although considerable callus reaction occurred in the periosteal areas of the bone, no effective union occurred between the intramedullary portions of the radius and ulna and the intramedullary grafts, this adverse reaction ultimately resulting in complete dissolution of the grafts and the failure to achieve ankylosis.

used alone it can scarcely achieve the desired end but may be combined with other grafts such as multiple chips (fusion) to act as a limiting membrane and establish continuity between the chips. As a wrap around an ununited fracture site I have rarely noted any appreciable benefit from it alone in the subsequent restoration of the integrity of the bone.

The sliver graft of Albee which contains all the layers of bone and is cut out of the side of the gutter in the source bone with a motor saw has mechanical continuity, adapts itself readily to irregular bony contours because of its thinness, and is a valuable supplement to other grafts. These grafts can also be used in groups to overlap each other where an extensive area is to be grafted or a large mass of bone is to be covered, because they readily acquire a blood supply and increase in size and strength in response to Wolff's law, thus providing sturdy regeneration of bone, which may be particularly useful in the lower back.

3. *Multiple Chip.* The multiple chip grafts of Hibbs (see figure 3) were first used in achieving spinal fusions but have since been adapted to many other situations. These chips derived locally at the site of the fusion or from other abundant sources, such as the pelvis and tibia, ultimately form a firm mass of bone which is particularly useful in the treatment of spinal tuberculosis, spondylolisthesis, and the like. Recent modification of the original spine fusion technic of Hibbs by Henderson, Henry, and Lewin has improved the efficacy of this type of graft tremendously.

4. *Dowel.* The dowel graft of Albee (see figures, 4, 5) is particularly useful in fractures of the hip both recent and old, but is also applicable to fractures of the condyles and joint fusion procedures. The dowel is cut by the electric dowel shaper from a tibial

or other suitable graft and is fitted accurately into a tunnel in the host bone cut by a burr or drill of corresponding size. These grafts should be adequately large for the intended purpose and may be multiple (as suggested by Compere in hip fractures) if desired. Because they are practically always used in cancellous areas, these grafts readily acquire a blood supply and have a high degree of viability. Their advantage over metal fixation at the hip rests upon their ability to establish a living connection between the fragments, carrying with them some blood supply to the less viable capital fragment from the richly supplied intertrochanteric area. The principle and effectiveness of the dowel graft can be duplicated with a fibular graft which has been chipped along its edges to accept more readily the invasion of blood vessels. Relatively crude cone shaped pegs, as suggested by Haggart, have also been used to assist in the fusion of joints with excellent success.

5. *Onlay.* The onlay, or massive graft, of Campbell and Henderson has been evolved in its present state over a period of years and represents a sturdy medium for bridging bone where great strength is required. The graft consists of all four layers of the bone (usually tibia), which are laid across the fracture gap on the host bones after the latter have been bevelled off to receive it. Recent improvements in the use of this graft point to the necessity of bevelling the host bone down to the medullar canal so that all the layers of the graft are in apposition to the corresponding layers of the host. Because this graft is not self immobilizing, various methods of fixation to the host have been devised, all of which introduce some technical difficulties. Multiple autogenous or screw pegs through drill holes in the graft and host are difficult to make and insert, frequently break, and do not always satisfactorily maintain apposition between the graft and host; moreover, the drill holes in the graft weaken it and may cause later fracture. Metal screws have been used in the place of autogenous ones, but these introduce a foreign body which may not be sufficiently secure in the host bone to hold the graft. The recent adaptation of vitallium to bone graft surgery has been a distinct advance, and some of the original objections to metal in bone have been invalidated by its introduction. In my experience, absorbable materials such as kangaroo tendon, catgut, and even silk have not been satisfactory because their tensile strength is frequently inadequate, they occasionally autolyze sooner than expected, and

Fig. 2. Roentgenogram of advanced tuberculosis of the fourth and fifth lumbar vertebrae stabilized and arrested through the performance of a modified Hibbs (chip) and Delageniere (osteoperiosteal wafer graft). The dense mass of bone welding the laminae of the third lumbar to second sacral vertebrae can readily be seen.

Fig. 3. A massive sliding graft consisting of the entire anterior cortex of the tibia resulting from the loss of a lesser fragment following serious comminuted fractures of the tibia. The space intervening between the fragment ends is filled with bone chips, while the massive graft is held in position with sturdy rustless steel wires. It should be noted that the twisted ends of the wire have been pushed into the space between the host and graft bones, thus preventing their ultimate protrusion through the soft tissues and skin.

their presence acts as an irritant to the tissues, in many instances leading to later breakdowns of the wound and occasional infection. Rustless steel wire has been employed in a number of recent cases with complete satisfaction. This is due to its great tensile strength, its lack of irritating or electrolytic reaction in the tissues, and its effectiveness in drawing and holding the graft to the host by employing the most recently devised special instruments for its application and fixation. Even the objection to the loose twisted end of the wire loops has finally been overcome by pushing these ends into the fissure space between the graft and host or turning them back through previously provided drill holes in the bones. The objection to the size of this type of graft in obtaining closure of the wound over the ulna or tibia has been eliminated by placing the graft on the deep side of the host bone so that it will not lie between the skin and the bone. Burns has found that such placement of tibial grafts not only overcomes the objection to their size but also expedites and insures their union, leading to success under the most adverse circumstances.

Fig. 4. Massive sliding and onlay type of graft held in position with five autogenous bone pegs employed for the restoration of the integrity of a tibia which had become defective through nonunion following a fracture.

I have recently applied the sliding principle to this graft by splitting the host bone longitudinally above and below the fracture level and sliding the long anterior portion of one fragment across the fracture line, securing it to both fragments after the short an-

terior portion of the other fragment has been shifted to the space created in the first. With this massive shifting of bone, rather large gaps can be bridged, thus eliminating the necessity of shortening the limb in such instances.

6. *Inlay.* Perhaps the most physiologic and certainly the simplest of all types of grafts is the original inlay graft of Albee. This graft can be cut most satisfactorily and expeditiously with a motor saw of one kind or another and must fit accurately into a gutter of the host bone. When properly cut and inserted, the graft apposes its four layers to the corresponding structures of the host, has wide areas of contact with the host bone for the acquisition of an abundant blood supply, and is almost automatically self retaining and immobilizing. This type of graft has a high percentage of success in properly selected cases, does not require mobilizing or extensively exposing the host bone, is easy to obtain either locally as a sliding graft or elsewhere as a transplant, and does not change the size or shape of the bone being restored.

Pitfalls and Complications

While the results of bone graft surgery are highly favorable in competent hands, such success can be attained only by a full understanding and respectful regard for the principles upon which it is based and the avoidance of the numerous pitfalls that lead to complications and failure. Operations of this nature should not be undertaken upon bone which is frankly or doubtfully infected and should not be attempted sooner than six months after such infection has been completely eradicated. Extensive areas of scar tissue should be excised and the wound closed by plastic or transplantation operations as a preliminary procedure to bone graft surgery so that the blood supply to the area is most favorable at the time of the latter operation. The bone graft operation should be planned carefully in advance so that the most promising and adaptable type of graft is chosen for the particular problem at hand, the incision must be made in such a manner that blood and nerve supply to the field are least damaged, the operating time in the bone graft field must be utilized efficiently by securing and preparing the graft from a remote source in advance or having two surgical teams at work simultaneously, thus requiring minimum use of the tourniquet and exposing the field of restoration the shortest possible time. Even the anesthetic to be used must be chosen with due regard to its explosiveness and other qualities if electromotive equipment is to be employed. After the graft has been placed the reconstructed part

Fig. 5. Inlay graft in radius for ununited fracture. The self-retaining features of this graft, achieved by mortising it in the host bone, are clearly evident in these roentgenograms.

must be handled with due regard to its strength until adequate external immobilization is provided. It is generally unwise to repose too much confidence in the strength of the newly established internal architecture by omitting external protection, because inadvertent and unexpected strains upon artificially restored parts may cause early disaster and completely defeat the objective sought. Continued maintenance of maximum circulation in the part (when an extremity is involved) is important; this can most effectively be achieved by keeping the limb elevated above the level of the heart after the operation until all peripheral swelling recedes. Function in the hand or foot should be preserved throughout the convalescence by exercising all exposed parts as much as possible consistent with complete immobilization of the grafted area. If the wound should become infected, fenestration of the cast, establishment of adequate drainage, and preservation of immobilization under all circumstances should be enforced. Often sufficient graft can be salvaged to achieve a successful result despite a complication of this type with or without sloughing of soft tissues and even portions of the bone.

Wartime Amputations*

The Value of End Bearing Stumps in the Lower Extremity

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THE world is at war, and surgeons again face the reconstructive problems arising from war wounds. Of these one of the greatest is that concerned with amputations and especially with amputations of the lower extremity. The rehabilitation of the soldier who has lost his leg is as much dependant upon the kind of stump he possesses as upon the quality of the artificial limb he is using. This paper is limited to amputations of the lower extremity since they present the major problems in amputation surgery. There alone can one hope to achieve a functional result at least remotely comparable to the function of the limb which has been lost. In amputations of the upper extremity, no matter how well performed and no matter how ingenious the prosthesis, the complex and delicate function of the lost hand can never be replaced.

In spite of a vast amount of experience regarding amputations which surgeons in England, America and Canada accumulated during the last war, there still is considerable diversity of opinion upon certain points of fundamental importance. With the prospect that we must again deal with large numbers of amputations, it is important that we should assess our past experience and clarify the principles which underlie amputation surgery.

Two important and authoritative statements on the subject of amputations recently have been published: one in the form of a monograph from the British Ministry of Pensions; the other in a series of articles in the *Journal of the American Medical Association.* This series is the product of a committee of surgeons and artificial limb makers. Both these publications condemn end bearing stumps in the lower extremity. This is an opinion so completely at variance with Canadian experience that it cannot be permitted to pass unchallenged. We have found end bearing stumps so satisfactory that we regard them as the amputations of choice. Their condemnation, bearing the weight of authority of the British Ministry of Pensions and the American Medical Association, is fraught with grave danger if it results in the assumption that end bearing stumps give bad functional results and such amputations should not be performed. The reverse is the case, for reasons which must now be discussed.

The most important function of an amputation of the lower extremity is its ability to

* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

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bear the body weight. If it cannot bear the whole of the body weight without discomfort and for long periods of time, it will be of little use to its owner no matter how well controlled its movements may be. Ability to bear weight is therefore the first and most important requirement of a lower extremity stump.

There is only one completely satisfactory manner in which weight can be borne by an amputation of the lower extremity, and that is on the end of the stump. However, satisfactory end bearing stumps can only be obtained when certain fundamental requirements can be achieved. There are two such requirements.

First, the skin which will cover the end of the stump and bear the whole of the body weight must be skin which normally is accustomed to bear weight. Weight bearing skin is adapted to its function by its greater thickness, the absence of hairs and the thickness and denseness of the underlying subcutaneous tissue. No other type of skin will bear weight satisfactorily, and skin with hair follicles is especially prone to trouble.

Second, skin of the quality suitable for weight bearing must be supported by the broad cancellous end of a bone.

There are only two situations in the lower extremity where these requirements can be met: 1. In the vicinity of the ankle the weight bearing skin of the heel can be utilized, and it can be supported either by the os calcis, as in Pirogoff's amputation, or by the lower end of the tibia, as in Syme's amputation. 2. In the vicinity of the knee, the weight bearing skin over the patella can be used to cover the end of the stump, and it can be supported by the patella fused to the femur, as in Stokes–Gritti's amputation, or directly by the condyles of the femur, as in Stephen Smith's disarticulation. These are the two situations in the lower extremity in which satisfactory end bearing stumps can be made, and amputations here give by far the most satisfactory stumps.

For a variety of reasons, it is not always possible to amputate the lower extremity and obtain an end bearing stump. If the foot is so damaged that the heel flap cannot be saved, then the amputation must be performed above the ankle, preferably about the middle of the tibia. In such a case, the weight of the body is borne on the rim of the bucket of the artificial leg, which presses against the under surface of the flaring condyles of the tibia. Similarly, if amputation cannot be performed through the knee but must be performed through the thigh, the weight is borne on the rim of the bucket which presses against the tuberosity of the ischium. The patient sits on the rim of the bucket of the artificial leg.

There are, then, four main types of amputations for the lower extremity: 1. The end bearing stump in the vicinity of the ankle joint covered with the heel flap. 2. The below knee amputation through the tibia, bearing weight by lateral pressure on the flaring condyles of the tibia and the head of the fibula. 3. The end bearing stump in the vicinity of the knee, bearing weight on the skin over the patella. 4. The midthigh amputation in which the patient bears his weight by sitting on the upper rim of the bucket of the artificial leg.

Of the weight bearing stumps in the vicinity of the ankle, the best is the amputation of Syme. In this, the amputation is performed through the lower end of the tibia just above the ankle joint, and the heel flap, which is preserved, is utilized to cover it. It is by long odds the best of all the amputations of the lower extremity. The heel flap which covers it is well adapted to bearing weight. The patient can stand and walk on it as much as he wishes. The expanded lower end of the tibia just above the ankle joint provides a broad and satisfactory foundation for the weight bearing flap. The space between the end of the stump and the ground is sufficiently great to permit the artificial limb maker to build into the limb a satisfactory ankle joint. This cannot be done in Pirogoff's amputation. The patient with a Syme's stump can walk, after a fashion, without any appliance. This is a point of some importance for his comfort, since it permits him to get out of bed at night without crutches. It is true that the artificial limb for it must be strong in order to withstand the great stresses which it is called upon to bear. This necessitates heavy reinforcement with metal

which, in turn, makes the limb big and heavy. For male patients, the appearance of the artificial limb is of no importance since it is entirely covered by the trousers. Only in special circumstances can Syme's amputation be used for female patients. The artificial limb is more unsightly than they will wear. Light metal alloys have done much to reduce the problem of weight.

The great merit of Syme's amputation is that it permits the patient to stand and walk without any restrictions. Therefore, he can engage in heavy occupations such as farming and truck driving. The gait is natural and not fatiguing. No other amputation of the lower extremity permits the patient to do so much or so nearly restores him to normal function. It is one of the great operations of surgery. In our hands, Syme's amputations, almost without exception, have given entire satisfaction. We have seen nothing of the complications complained of by the British Ministry of Pensions, trophic ulceration and poor circulation. I am of the opinion these are the result of poor limb fitting and are not the fault of the amputation itself.

Like all end bearing amputations, Syme's amputation must be carefully performed. The two faults which must be avoided are a misplaced flap and a loose and wobbly flap. The flap must be so fashioned and sutured that the weight bearing skin lies squarely beneath the divided end of the tibia, and care must be taken at the end of the operation to apply the dressing in such a fashion as to insure this. Again, if the flap is loose it will slide about when the patient bears weight on it. To avoid this, trim the flap so that it fits snugly when the wound is closed.

The below knee amputation through the middle of the tibia has its merit, especially if the patient does not have to be on his feet all the time. He can walk with a reasonably natural gait, and the artificial limb closely resembles the normal in appearance. Hence it is the operation of choice for women. But it will not stand prolonged weight bearing or strenuous use. The manner in which weight is borne by lateral pressure on the sloping upper end of the tibia is mechanically poor. The stump plunges up and down into the bucket as the patient walks, and when weight is borne the stump is wedged tightly in the bucket. The hairy skin stands pressure poorly. Sooner or later infections occur in hair follicles which necessitate changes in the shape of the bucket, prevent the wearing of the leg, or necessitate operation to excise the involved skin. The manner in which the stump is jammed into the bucket interferes with the venous return, and this, in turn, results in chronic edema of the end of the stump. The swelling so produced aggravates still further the circulatory difficulties until a vicious circle is set up in which venous obstruction causes edematous swelling of the end of the stump, and this in turn aggravates the venous obstruction. The condition is known as "choked stump." It results ultimately in edematous eczema of the end of the stump with fissures in which infection occurs. When "choked stump" develops, nothing but reamputation satisfactorily solves the problem.

In our experience, virtually every below knee stump gives trouble of greater or less degree. In some, these troubles are of minor seriousness, and even though they are recurrent they do not seriously incapacitate the patient, especially if his occupation is sedentary. In others the trouble becomes more serious and ultimately leads to reamputation, especially if the man must be on his feet all day. Below knee amputations are useful functionally only when the patient can live a sedentary life. They cannot be expected to stand the strain of prolonged walking and standing.

In below knee stumps which give continuous trouble, it has been our custom to reamputate the limb by the Stokes–Gritti method, and many Canadian soldiers have had their unsatisfactory below knee amputations transformed by this method with complete satisfaction. The loss of voluntary control of knee joint movements is more than compensated by the entire freedom from stump troubles. Consequently, they can engage in occupations which keep them on their feet, and they never have trouble with the stumps.

Stokes–Gritti's amputation through the condyles of the femur is the best amputation above the knee. Properly performed it gives

a satisfactory end bearing stump which is painless and permits any amount of standing and walking. The operation itself presents some important problems in technic, but they are not beyond the capacity of the average surgeon. However, it is important that the patella be firmly fused to the femur and in the proper position. If bony fusion does not occur, or if the patella is fused in a tilted position, weight bearing will be painful. With the patella fused in satisfactory position, painless weight bearing on the end of the stump will be achieved.

Some limb makers seem to encounter difficulties in fitting the Stokes–Gritti stump, though there should be none. It is certain that satisfactory limbs for this end bearing amputation can and are being made.

Amputations above the knee through the substance of the thigh and the shaft of the femur are often necessary because of the nature of the trauma. If at all possible, the Stokes–Gritti amputation should be performed. Only if this is impossible should the midthigh amputation be used. The resulting stump, of course, has grave limitations. There is no voluntary control over the knee joint movements, and if the stump is short there may be imperfect control of the artificial limb. Nevertheless, thigh stumps of reasonable length can be remarkably useful, and with a good artificial limb such an amputee can satisfactorily conduct a sedentary occupation and lead a useful life. The same difficulties in the weight bearing skin as in the below knee amputations are prone to occur though to a less degree.

It cannot be emphasized too strongly that in amputations of the lower extremity the end bearing stumps (Syme's and Stokes–Gritti's) are by far the most satisfactory of all amputations. Wherever possible these are the amputations which should be performed. Below knee amputations and midthigh amputations are decidedly limited in the degree of function they can restore, and in addition are prone to certain surgical complications due to weight bearing on hairy skin and vascular changes in the stump. Many poor below knee stumps are improved by reamputating by the Stokes–Gritti method.

Some of the objections to the end bearing stumps come from limb fitters. Undoubtedly they are less easy to fit, but satisfactory limbs can be made for them. Too often there is a complete lack of co-operation between surgeon and limb maker. The surgeon knows nothing of the limb maker's problems and cares less. The limb maker has little realization of what the surgeon is striving for and tends to adhere rigidly to the methods he has acquired by long experience. In Canada we have been fortunate in having for soldiers a limb factory which is an integral part of the Soldiers' Hospital at Christie Street in Toronto. There the whole problem of the amputated limb is under the control of a single group of surgeons, the primary injury, the primary amputation, the type of limb to be supplied, the fitting of the limb, the supervision of the patient after discharge, and all subsequent treatment which may be necessary to his stump. A great experience in stumps of the lower extremity and in artificial limbs has thus been built up. I am certain that this intimate correlation of the surgery of amputations and the manufacture of suitable prostheses has much to do with our satisfactory experience with end bearing stumps.

I am indebted to my colleague, Dr. Gordon M. Dale, for the following figures compiled from amputations performed on soldiers, figures which support the statements made in this paper:

Of 233 thigh amputations (40 per cent nine inches long or longer),
- eighty-three had skin lesions on the bearing surface;
- fourteen had skin lesions on end of stump;
- fifty-four had painful neuromas;
- twenty-six were not wearing the leg;
- fifty-six were satisfactory.

Of 130 Stokes–Gritti's amputations,
- twenty-four have been wearing legs twenty-one years or more;
- sixty-six have been wearing legs ten years or more;
- four have been reamputated (osteomyelitis);
- five have had prepatellar bursitis cured by removal of bursa;
- one has had sequestrum of patella, cured;

two have had extruded kangaroo tendon knots, cured;
all except those reamputated have satisfactory stumps.

Of 120 below knee amputations (seventy-one six inches long or longer),
almost all have had some trouble with the stump, 40 per cent of them continuous trouble with fibromas, hair follicle infection or caked stump;
ten are bearing weight not on the stump but on the corset tightly laced about the thigh;
four are bearing weight on the flexed knee;
16 per cent have painful neuromas;
in addition, 50 other cases had been reamputated by the Stokes–Gritti method.

Of 60 cases of Syme's amputation,
eighteen have been wearing their limbs twenty-one years or more;
twenty have been wearing their limbs eleven years or more;
two had misplaced heel flaps cured by plastic operation;
one had inclusion cyst about catgut knot, cured;
one had painful neuroma;
one had bursa.

The Use of Spool Cotton as a Suture Material

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IN THE next few months the use of cotton will doubtlessly supplant silk as a nonabsorbable suture material. When it is realized that its cost is but a fraction of that of the other popular suture materials, both absorbable and nonabsorbable, it should certainly find its place in the present war economy. At present, cotton suture material does not seem to be widely used.

As early as 500 B.C. Susruta[1] recommended cotton for the suture of wounds of joints and the abdomen. It has doubtlessly been used in many isolated instances since that time. In 1939, Meade and Ochsner[1] reported on their use of cotton in 196 operations, which were the general types of major surgical procedures. They reported that healing by primary intention occurred in 191 cases. They showed from experimental study that cotton produced less cellular reaction of tissue (rabbit) than silk, linen or catgut (in the order named). They further reported that, whereas dry cotton has less tensile strength, size for size, than catgut, silk or linen, after being boiled twenty minutes it increases 10 per cent in tensile strength, and when it is placed in the tissues, it shows much less decrease in tensile strength (break strength) than the others.

We feel that the latter points are of considerable importance. We must admit that when suture material of considerable original tensile strength, such as chromic catgut, was used, there was a tendency to apply considerable force in approximating the tissues. This would often produce a strangulation and subsequent necrosis of the tissues with the establishment of a focus of lessened tissue resistance. This is especially true in herniorrhaphies in which tissues which ordinarily do not adjoin are pulled together. The use of suture material with less original tensile strength is of advantage in that it must be handled with care, and approximation must be made without force, or the sutures will break.

Thorek[2] reports favorable results in the use of cotton in 150 major surgical procedures. It is interesting to note that he reports its use in cases as they came, whether an interval appendix or a perforated appendix with an already contaminated wound. In his series there have been no sinus tracts formed. It has also been used by him in conjunction with catgut with no ill effects.

Cotton and silk produce little inflammatory reaction and thus result in a "dry" type of healing which is associated with a minimal amount of exudate. Fibroblastic proliferation appears early. Catgut and other absorbable sutures produce an increased ex-

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udation, which Gage[3] has termed "wet" type of healing. In this type of healing there is an increased cellular reaction with subsequent induration of the wound.

At the Milwaukee County Hospital we have become very enthusiastic over the use of cotton suture material and have been using it the past eight months on most of our herniorrhaphies, thyroidectomies and an increasing number of other major and minor surgical procedures. We have used cotton in seventy-eight major operations. Most of these have been done by the author and members of the resident staff. We have not urged its use on the attending staff and so have had a chance to compare the postoperative courses in patients in which various suture materials have been used. The ages of these patients have varied from five years to sixty-one years. We have kept our patients in bed for the same length of time as when other suture materials have been used. However, one patient got up on the eighth day following an inguinal herniorrhaphy with no apparent immediate complication. A minimal amount of tissue reaction has been noticed. Some induration along the incision was noticed in one herniorrhaphy. In another herniorrhaphy for an incarcerated inguinal hernia in a patient with an old residual hemiplegia in which tissue turgor was poor, a subcutaneous hematoma developed with subsequent infection and drainage. The infection responded to moist hot compresses, and at no time was any suture material extruded from the wound. There has been no recurrence of the hernia. Of the 54 patients on whom herniorrhaphies of varying types and technics have been done, there has been one known recurrence to date in a patient who had a chronic bronchitis.

It was interesting to note that in one patient with a bilateral inguinal hernia, cotton suture material was used on one side and silk on the other. Both wounds healed in approximately the same time. After a period of four months the patient was re-examined, and the healed wound on the side on which cotton was used was slightly more pliable. (At the time of the examination it was not known on which side cotton had been used.) However, we feel that from the clinical standpoint there is little noticeable difference in wounds sutured with silk or with cotton.

We use the ordinary 5 cent spool cotton which is made of six twisted cords. Mercerized spool cotton, made up of three cords, can also be used. Sufficient quantity for the surgical procedure is wound on two or three glass rods or tubing, or on wooden spools, and boiled for thirty minutes. We estimate the total cost of the cotton suture material for one major surgical procedure to be less than 1 cent. We have been using no. 30 spool cotton for the deeper tissues and no. 50 for the subcutaneous tissues.

We have used nothing but interrupted sutures when working with cotton, following the tenets of Halstead.[4] However, Taylor[5] advocates the use of cotton as a continuous suture.

In conclusion, we may add a few disadvantages in its use. Due to its greater coefficient of friction, cotton suture material has a tendency to cling to the fingers. This is of advantage in the placing of knots, but it has been found that if the fingers are allowed to become soiled with clotted blood or serum, short ends may cling to the fingers and become annoying to the surgeon. Occasional fraying has been noticed. We do not advise the use of retention sutures of heavy cotton, as it has been noticed that when they are removed they cling to the tissues and cause considerable more pain to the patient than when silkworm gut or other similar types of retention sutures are used. However, if the cotton thread is waxed and autoclaved this disadvantage might be overcome.

Summary

1. We have found spool cotton to be very satisfactory as a suture material.

2. Sterilization is obtained by winding the cotton thread on glass rods, tubing or wooden spools and boiling for thirty minutes.

3. Of seventy-eight major surgical procedures in which cotton was used, there has been one superficial wound infection.

4. Cotton suture material is economical and should find its place in our present war economy.

Author's Note: My thanks are due to Lieutenant John J. Satory, M. C., who collaborated with me in the writing of this article.

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Ocular Evidence of Head Trauma*

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THE developments of industry and mechanization, automobile accidents and modern warfare are causing an increasing number of head injuries. Aside from direct damage to eyes, the ocular manifestations afford aids to diagnosis and determination of the extent and prognosis of brain involvement. Time will not permit extended discussion of the dynamics or mechanisms by which the eye is involved in head injuries.

Ophthalmologists are frequently called (but not too often) into consultation in cases of skull fractures, concusion, hemorrhage, or laceration of the brain for any possible clinical diagnostic aid. Evaluation of residual visual impairment, muscle imbalance or other permanent damage to one or both eyes demands meticulous diagnosis especially in forensic problems and evaluation of claims for compensation or pension, to determine the cause and extent of eye involvement and to exclude malingering.

In a review of 610 skull fractures, Blakeslee[1] found eye changes occurred in 78 per cent of patients. The changes ordinarily observed after head traumas are:

1. Ecchymosis and hemorrhage into the lids, conjunctive or orbit.
2. Paralysis of extraocular muscles including ptosis.
3. Nystagmus.
4. Pupillary.
5. Field changes.
6. Fundus and optic nerve changes.

There is one general rule which applies in severe head traumas, namely, that when these are accompanied by *early* eye symptoms the prognosis is more serious than when no eye involvement occurs.

Pupillary changes occur in about two-thirds of all basal fractures. Pupillary anomalies frequently become normal in a few days, but, until they do so, one should withhold mydriatics and, if possible, morphine. Inequality of the pupils combined with absence of reaction usually signifies intracranial hemorrhage. Fixed miosis may be present: if no reaction whatever occurs it is indicative of serious trauma, though less so than when both pupils are widely dilated. All authorities agree that when both pupils are widely dilated and fixed *on admission*, the prognosis is grave. In Blakeslee's series this occurred in 55 patients, 52 of whom died. A unilateral dilated fixed pupil, of itself, is not necessarily on the side of an epidural hemorrhage. It may be due to direct injury to the optic nerve on that side. In such case the consensual reaction is present, or it may be due to pressure upon the entire cerebral hemisphere. However, Rand[2] states, "In cases in which hemiplegia and the dilated pupil were homolateral, intracranial hemorrhage was found on the same side." Neurosurgeons usually consider the combination of homolateral hemiplegia and dilated pupil a definite indication for exploration or decompression of fracture or hemorrhage on the same side.

Nystagmus occurs principally in lesions of the posterior fossa. It is not so often observed, but may be very frequently *elicited* by vestibular tests. The frequent vertigo and postural dizziness complained of is usually indicative of vestibular nerve involvement. One can attach little diagnostic significance to nystagmus.

* Presented at the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

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Extrinsic muscle paralysis with diplopia is generally observed *soon* after head injuries. The sixth nerve is most commonly involved after basal fracture or hemorrhage because of its longer course over the base of the skull and vulnerable position as it passes over the crest of the petrous portion of the temporal bone. Paralysis of the orbicularis from seventh nerve involvement is fairly frequent with basal fractures involving the petrous temporal bone; auditory and vestibular symptoms also are common from associated eighth nerve damage. Involvement of the seventh and eighth cranial nerves should invariably arouse suspicion of temporal bone fracture.

The trochlear (fourth) nerve is rarely involved singly.

Third nerve involvement in its entirety is *very uncommon* and makes one suspect fracture through, or pressure within, the superior orbital fissure, especially if total ophthalmoplegia exists with corneal anesthesia from damage to the first division of the fifth. In such case corneal ulceration may occur unless ptosis is present. However, involvement of branch fibers of the third is by no means uncommon after head injuries. When the intrinsic fibers of the third are paralyzed, it always implies a serious nuclear or central lesion with grave prognosis—more so if *both* pupils are spastic and dilated, as previously mentioned.

With *late* involvement of any of the cranial nerves after injury one thinks of possible callous formation, inflammatory exudate, meningitis, rarely of aneurysm, and more rarely, as Cushing[3] has shown, to arachnoiditis.

One should not emphasize the *localizing* value of ocular palsies with cerebral or skull trauma, nor are they usually a reliable index of the severity of damage. Prognosis for recovery from all types of extra ocular palsies is often surprisingly good, although four to eight months may lapse before diplopia disappears. Even so, a residual paresis may be helped by prism correction, and an occasional patient may be made happy by operation upon the lateral rectus. *Early* surgical correction is *never* indicated, and compensation claims should be deferred until time is allowed for natural recovery.

Ecchymotic extravasations in the lids or conjunctiva occurred in approximately 17 per cent of the 610 skull fractures reported by Blakeslee.[1] Hemorrhage occurs from direct injury to orbital blood vessels, from extravasation along the nerve sheath into Tenon's capsule or into orbital tissues and lids in the majority of orbital fractures. Even without corroborating roentgenograms, ocular hemorrhages make one suspect basal fracture involving the anterior fossa.

Intra-ocular hemorrhage of subarachnoid origin may cause very serious visual damage, as in the following case:

A man, aged forty-nine, in November, 1931, fell on a concrete pavement and was found unconscious with stertorous breathing, spasticity of the left arm and a slight cervical rigidity. He was unconscious four hours. The pupils were equal and reacted normally. No immediate examination of the eyegrounds was made. He complained of severe headache, was nauseated on regaining consciousness, and complained of loss of vision.

Ophthalmologic examination revealed extensive vitreous hemorrhages in each eye. Vision in the right eye was nil. There was extensive hemorrhage around the left disc. Spinal tap twenty-four hours later showed bloody fluid. Roentgenography showed widening of the right temporal zygomatic suture line but no definite basilar fracture. When examined by me twenty days after the injury, fundus details could not be made out because of extensive vitreous hemorrhage. Vision in the left eye was present, but owing to the patient's mental confusion could not be determined. He had suffered intracranial hemorrhage which probably extended along the sheath of the optic nerve, breaking through the hyaloid membrane in each eye, producing the extensive bilateral vitreous hemorrhages and, ultimately, the complete retinal separation in the right eye; or hemorrhages may have occurred directly in the nerve sheath. In either case a block or stasis in the neural, vascular circle of Zinn or short ciliary veins occurred.

Six months after this accident the detachment in the right eye was complete. In the left eye all the retinal hemorrhages had been absorbed, but extensive vitreous opacities remained. Vision was 20/20. Death from cerebral hemorrhage occurred six and one half years later.

Hemorrhage into the optic nerve sheath was present in 10 per cent of autopsies following head injury in Pringle's[4] series; 7.5 per cent showed fracture through the optic foramen. Paton's explanation of ocular evi-

dence of subarachnoid hemorrhage *without* trauma, quoted by Calhoun,[5] is probably correct and applies in cases of trauma also, "that 'they are due to direct leakage of blood from the sheath through the lymphatic spaces at the sides of the lamina cribrosa and along the central vessels into the disk head and retina and preretinal tissue.' "

Aside from such rare instances as the above, cases with cerebral apoplexy (following trauma or otherwise) practically never reveal any *early* evidence of papilledema or any change in the nerve head or retina other than arteriosclerosis. Papilledema may be found four to six days later.

Eagleton[6] has stressed the necessity of repeated daily fundus examination, for papilloedema develops from increased intracranial pressure more often in cases of secondary edema of the brain, or with encysted hematoma, but it depends upon the localization and direction of increase of intracranial pressure. He contended that "injuries confined to the anterior part of the frontal lobe do not produce papilledema. Injuries of the posterior fossa *with* occlusion of the iter produce a high degree of papilledema. Injuries of the cerebral hemispheres with secondary edema produce a moderate degree of edema with but little swelling. This papilledema may last for months, or may rapidly disappear."

The value of early and repeated ophthalmoscopic examination is illustrated in the following case:

On January 1, 1940, following an automobile accident, the patient was unconscious fifteen minutes, confined to the hospital two weeks and released. He suffered another attack of unconsciousness of short duration, followed by severe and frequent headaches and weakness of the right leg. When admitted to the University Hospital, May 17, 1940, for observation, he had *choked discs* of three diopters. Visual fields could not be taken. A left temporal craniotomy was done on May 22, and the remains of the hematoma removed and drainage provided. When the patient was discharged after two weeks, the fields in each eye showed contraction to about the thirty degree isopter. Vision was right and left 20/30. On January 21, 1941, ophthalmoscopic examination showed secondary disc changes with slight pallor. There were no further changes in the peripheral field loss, and vision was still 20/30 in each eye.

There was no eye examination of this patient until four and a half months after the accident. Had ophthalmoscopic consultation been requested earlier, the choked discs would have been seen and steps taken to determine the cause of increased intracranial pressure.

Optic atrophy and *field* changes must always be considered, especially in medicolegal cases. Basal skull fracture involves the roof of the orbit, the clinoid processes, or the optic foramen so frequently, with possible hemorrhage into the nerve sheath and impingement of the optic nerve or damage to the chiasm, that one must observe these cases over long periods to evaluate the damage. Atrophy may be evident as early as one week or rarely as late as three months after injury to the nerve.

In a case of my own a man fell down an elevator shaft and suffered a concussion of the brain. He immediately complained of complete loss of vision in one eye. There was no fundus disease evident, and there were almost no external evidences of injury aside from laceration of the scalp.

Roentgenography was negative. Six weeks later definite optic atrophy appeared on the affected side. What had happened? The assumption was that he must have had a fracture through the optic foramen or clinoid process with impinging of the nerve but without sufficient hemorrhage to cause external orbital or ocular symptoms or any immediate fundus change.

According to Rawlings,[7] postmortem evidences indicate that this happens far more frequently than can be demonstrated radiologically.

Certainly there is abundant evidence that optic atrophy may be produced by direct compression independent of hemorrhage. Optic atrophies occur in only a small proportion of the sequelae of head traumas, but they cause serious visual impairment. These are mostly descending unilateral atrophies and appear late, as in the case cited of the man who fell down an elevator shaft.

Barkan and Barkan[8] have shown that the resulting loss of vision may be due to a fracture of the anterior clinoid which, according to Ballantyne,[9] is found at postmortem less frequently than fracture of the foramen. Unfortunately it is most difficult to demonstrate roentgenographic evidence of fracture of the optic canal and clinoids, and nerve damage

may be in the intracranial, canalicular or orbital division of the nerve. With primary optic atrophy following fracture of the foramen or clinoid process, no improvement of vision is likely unless pressure can be relieved by decompression of the foramen.

According to autopsy findings, ordinarily only one optic nerve is involved in basal fractures. According to Cantonnet,[10] bilateral damage occurs in only 7.5 per cent of cases. With bilateral involvement, one must suspect extensive basal hemorrhage, fracture of both optic foramina or of the sella turcica. Syphilis is the other, most common cause of *bilateral* atrophies, and with a history of trauma, if both nerves are atrophic, one should be careful to exclude syphilis, even though a trauma may also be an exciting or contributing factor.

Another consideration of interest is that late, gradually developed traumatic arachnoiditis may explain delayed atrophy and blindness, as shown by Cushing[3] and others. Only recently have ophthalmologists learned to appreciate this possibility.

Another example of basal fracture followed by optic atrophy is here recorded, in which field changes were not those one ordinarily sees with simple atrophy:

A boy, aged nine years, was examined on July 7, 1923, four weeks after an automobile injury. The head had been traumatized severely by the wheel of the car. Vision was 20/50 and 3/200. There were macular hemorrhages in both eyes, and both optic nerves were pale, especially the left. A record of the fields was impossible at the time, but six weeks later they showed a definite ring scotoma in the right eye and a central scotoma in the left eye with concentric contraction and vision of 20/30 and 20/65, right and left respectively.

On August 1, 1940, he came to me complaining of headaches during the last six years, unrelieved by glasses. The fields were practically unchanged from those taken seventeen years previously. Vision in the right eye was 20/15; in the left he could count fingers at one foot. There was a slight temporal pallor of the optic nerve and a definite atrophy of the left optic nerve.

In this case it was difficult to explain the formation of a ring scotoma. It resembles somewhat the delayed optic atrophy following callous formation from a fracture extending into the optic canal, as in the two instances reported by Lillie and Adson.[11] In each of their cases there was no ophthalmoscopic abnormality whatsoever. Roentgenograms of the skull were negative, and vision was good for a time after the injury. Later visual symptoms developed with roentgenographic evidence of pressure upon the nerve due to formation of callus. Examination of the fields of vision showed unilateral, central and annular scotomas which might be interpreted as a form of nueritis. Decompression of the optic canal in one case did not relieve the condition because it was done after nerve injury had become permanent. Adson stated that, in the one case that was decompressed, the "fragment had been cracked loose and consisted of a portion of the anterior clinoid process, and part of the greater wing of the sphenoid. The crack extended from the anterior clinoid process into the optic canal but apparently no pressure developed until the callus began to form and filled in the optic canal."

Osterberg[12] described a type of field change with chiasmal syndromes, which suggests that widening of the distance between the optic foramen, to which the optic nerve sheaths are adherent, may result in sagittal tearing of the sheath or even splitting of the chiasm in its middle, when trauma produces an anteroposterior compression of the skull. Coppez[13] showed experimentally that it was necessary to effect a spread of only 1.2 to 2 mm. of the optic foramina to produce a sagital tear of the chiasm. Traquair[14] believed bitemporal hemianopsia resulted from rupture of small blood vessels from the carotid to the chiasm, but this does not explain involvement of crossed fibers alone. Rucker[15] also recently reported a case of bitemporal hemianopsia supposedly due to such a mechanism. A similar one occurred at the Ancker Hospital, St. Paul.

On July 21, 1940, a man, aged thirty-one, was found comatose after an automobile accident. The lids were ecchymotic and the right pupil dilated and not reacting to light. Neurologic examination was negative excepting bilateral positive Babinski reactions and blood spinal fluid on successive tappings until August 7. Roentgenograms showed a fracture anteriorly in the sella turcica extending from the right frontal bone through the frontal sinus.

He was discharged from the hospital on September 22. On perimeter test on November 25, 1940, because of complaint of poor vision, bitemporal hemianopsia was present. Vision in the right eye was counting fingers at six inches. The disc showed visual acuity in the left eye was 20/25 because of sparing of the macula.

This case had undoubtedly *some* type of damage to the medial fibers crossing the chiasm, presumably a sagittal rupture resulting in hemianopsia, although it is difficult to explain the sparing of the macula in the left eye.

Ordinarily it is difficult to make visual tests or even confrontation field examinations soon after head traumas, and roentgenographic evidence is frequently not too valuable. Even minor head traumas may not show evidence of damage until weeks later as did the following case, the result of a vascular accident and not a fracture.

A boxer, aged twenty-three, was referred for operation for detached retina. During a bout one month previously he noticed limited vision to the left eye after recovering from a punch-drunk syndrome. Examination of the fundus showed no abnormality. The oculist who referred him had charted the fields but assumed that he had a detached retina because his father, also a pugilist, had suffered a detached retina. The fields remained unchanged after three years, and the condition can be interpreted only as a vascular accident in the optic radiations.

One cannot describe all ocular manifestations of head trauma such as retinal detachment, avulsion of the optic nerve, lateral deviation of the eyes, and atrophy from arachnoiditis. However, one other deserves special mention, namely, proptosis. This may occur, as in boxers, from simple fracture of the ethmoid with air emhysema. This is harmless, and treatment is simple. In fractures through any of the accessory sinuses, the proptosis, sometimes due to hemorrhage, may be alarming. Particularly in fractures of the sphenoid with injury to the carotid or cavernous sinus, proptosis may occur quickly.

Arteriovenous, cerebral or orbital aneurysm occasionally follows head traumas. In Locke's[16] series, 77 per cent of pulsating exophthalmos were of traumatic origin, and of these 94 per cent had an arteriovenous communication between the internal carotid and the cavernous sinus.

The following patient has been under observation for ten years, the only one among nine personally observed who has not come to operation:

A man, aged forty-seven, came to me on September 8, 1931, with a history of striking his head against the bathtub on May 10, 1931, followed by a severe headache. A week later he noticed double vision which disappeared for a time but recurred with development of exophthalmos on July 3, 1931. At the time of injury there was slight ecchymosis with swelling of the left eyelids. He was hospitalized for three weeks. Roentgenograms of the head were negative. During this time a bruit was detected over the left side of the head, most prominent over the upper inner angle of the orbit where the frontal vein was unduly prominent. During October 18 and 19, the "swish" in his left ear stopped almost immediately. He had some pain for a time which reappeared and disappeared during the preceding two months. Vision dropped to 20/200. Conjunctival veins were very engorged and varicose. There was also marked congestion of the retinal veins much as one sees in thrombosis, and there were hemorrhages around the nerve head. There had been a marked recession in the proptosis at that time.

He said he slept well and the noise was too slight to bother him. Exophthalmos measured right 21 mm., left 25 mm. On August 27, 1932, vision in the left eye was 20/40. There was much less congestion of the retinal veins. Bruit was audible only over the forehead and the eye and completely inaudible on compression of the left carotid. The paresis of the sixth nerve was complete; there was considerable contracture of the internus. The retinal vessels had diminished in size so that all vessels were now much smaller than those of the right eye. The thrill on palpation continued.

When last examined on May 14, 1941, he was having no discomfort; he disregarded the slight swishing noise in the left ear. The bruit was heard only above, over and beneath the left eye. Exophthalmometer measurements were right 19 mm., and left 25 mm. The retinal veins showed *no* dilatation, although the external conjunctival vessels were markedly engorged. No operation was attempted in this case since the patient did not feel that the inconvenience or interference with his work warranted operation.

The diagnosis of pulsating exophthalmos or orbital aneurysm of traumatic origin is usually not difficult. The exophthalmos, synchronous pulsation of the eyeball and conjunctival vessels with the heart beat, abolished by pressure on the carotid artery, *with* audible bruit transmitted to various parts of the head on the same side, and often on the opposite side, makes the diagnosis quite defi-

nite. However, the diagnosis *between* orbital aneurysm and arteriovenous aneurysm is not invariably certain. The point of differentiation is a pulsating swelling above the inner canthus, which is almost pathognomonic of arteriovenous aneurysm but is not present with orbital aneurysm.

In any event there is one thing to remember about nerve head changes, namely, that the importance of *early* fundus changes in connection with intracranial injuries is probably overrated. Papilledema and optic atrophy are by no means early signs. Both of these conditions usually require time to develop. Both may be produced by subarachnoid hemorrhage along the sheath of the nerve. Papilledema may develop from *long continued* pressure; e.g., from encysted hematoma, or as Eagleton pointed out, from a late cerebral edema. The necessity of repeated examinations is important.

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Injuries to the Abdominal Wall and Contents*

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THE acute traumatic abdomen may be divided into three main types; namely, lesions of the abdominal wall, retroperitoneal lesions and intraperitoneal lesions. Someone has said that the present era will be known as the age of speed. To those of us doing surgery, it is known as the era of accidents. Although technic and surgical judgment have improved, as the speed of a moving object is doubled, its energy (or destructive force) is increased four times; and as its speed is tripled, its energy is increased nine times. In other words, the energy of a moving body increases as the square of its speed.

There is probably no diagnosis requiring more finesse than the rapid differentiation in the diagnosis of the traumatized abdomen. Rapidity is important because all mortality statistics indicate that the longer surgical intervention is postponed, the more acutely the mortality rate rises. In all cases of abdominal injury the surgeon should look not only for signs of shock, internal hemorrhage and peritonitis, but also for signs of gas or fluid in the peritoneal cavity, for blood in the urine and bowel movements as well as for bleeding from the vagina.

History

The history is very important in this type of work; an exact word picture of the manner in which the patient was injured is often an aid in the diagnosis. The question of how recently food and liquid had been taken and when the bladder was last emptied

* Presented before the Centennial Anniversary Meeting of the State Medical Society of Wisconsin, Madison, September, 1941.

are also of value. Local or circumscribed blows more commonly injure the intestines, mesentery and bladder, while diffuse applications of force to the abdomen are more likely to result in damage to the solid and fixed organs such as the liver and spleen.

Pain is an important symptom. Attention should be paid not only to the location of the pain, but to the type of pain, whether constant or intermittent. Localized early pain, later spreading and becoming generalized, suggests leakage. In abdominal trauma beware of the four P's — *pain, prompt, persistent* and *progressive.*

Inspection

Inspection may determine whether a swelling is intraperitoneal, retroperitoneal or in the abdominal wall. When a movable tumor in the upper abdomen is intraperitoneal, it will go through a wider range of excursion with the diaphragm than when the swelling is retroperitoneal. A swelling in the abdominal wall comes up very prominently if the patient blows, with the nose held closed, while one within the peritoneal cavity will disappear from view due to the contractions of the muscles over it.

Palpation

The rigidity of the abdominal muscles in injury as well as disease is a measure of the degree to which the parietal peritoneum has been irritated. Of all the serous surfaces of the body, the parietal peritoneum appears to be the most sensitive, more so than the pleura, pericardium or the meninges.

The escape of any substance into the peritoneal cavity will usually cause distress, and the abdominal muscles will respond by reflex contraction in protection to the degree to which the parietal peritoneum has been irritated. The escape of the contents of the stomach or duodenum after perforation of an ulcer, or following injury, causes serious irritation to the parietal peritoneum. Perforation of the colon, even more hazardous for the patient, does not cause as much pain and immediate disability, for the contents are not so irritating.

If the examining hand is pressed gently into the abdomen at various places, and no tenderness, rigidity or spasm of the abdominal muscles are encountered, we should not conclude that the parietal peritoneum is not being irritated until we can satisfy ourselves that quick release of the hand (rebound tenderness) repeated at various places causes no distress. Turning the patient on his face, pressing the hand under the abdomen and palpating upward will sometimes elicit localized tenderness not found before, since it is difficult for the patient to contract his rectus muscles voluntarily while in this position. *Rigidity* and *tenderness* are two of the most constant and important findings in abdominal trauma.

Percussion

If it were not for the presence of gas in the intestines, the entire abdomen would be as dull to percussion as the liver. An area of unusual dullness in the presence of abdominal injury suggests the collection of blood in the peritoneal cavity. The demonstration of shifting dullness helps in determining whether ascites or encysted fluid is present. It takes about six quarts of fluid in the abdomen of the adult to give shifting dullness.

Auscultation

Auscultation of the abdomen is neglected far too much. The hearing of borborygmus with the stethoscope at the acme of the pain usually suffices to rule in or out the consideration of acute intestinal obstruction. Similarly, when distention is great and fluid separates intestinal coils, the heart sounds and even the breath sounds may be heard over the patient's abdomen. It is of particular importance to determine whether or not the injury is limited to the kidney, because operation is rarely indicated in such a case. Thirty cases of kidney injury at the Massachusetts General Hospital were studied by Allen. He found that in the 25 cases not operated upon, there were twenty-five recoveries, while in the cases operated upon there were four deaths. Davis says that in kidney injuries there is little pain if the capsule is torn and great pain if the capsule is intact. The diagnosis of kidney injury is made from the site of the contusion, the pain and the

finding of blood in the urine; an intravenous urogram may give considerable aid.

According to de Tarnowsky a simple contusion of the abdominal wall may be more painful than a visceral lesion before peritonitis sets in. Rupture of the rectus abdominis muscle is uncommon but usually occurs below the umbilicus. Cullen points out that when blood lies between the rectus muscle and the peritoneum the symptoms are usually those of an acute intra-abdominal lesion. A retroperitoneal hemorrhage will always cause symptoms of an acute intra-abdominal injury, and such cases are almost always subjected to exploratory operation.

Roentgenography

In abdominal injury, roentgenograph evidence, with reference to the absence or presence of free gas in the peritoneal cavity, is also most important. In cases of blunt trauma, this may be the chief factor in determining whether operation is necessary. If the patient is too ill, the film should be made in the erect or the lateral position with the right side up. A very small quantity of gas, 4 to 10 cc., can be made out beneath the diaphragm. Ruptures of the retroperitoneal duodenum and retroperitoneal portions of the colon have been diagnosed by the roentgenogram. Gas escapes about the kidney and can be easily visualized. Every patient who has suffered an injury to the back, abdomen or pelvic region should be asked to void immediately. If the urine is free from blood, we can feel reasonably sure that the urinary tract has escaped injury. If the urine is bloody, in fair amount and passes freely, we can conclude that it is from a contused kidney; but if the urine is scanty and bloody, or if there is bleeding from the urethra, or if the patient is unable to void, we then suspect an injury either to the bladder or urethra.

Attempts at catheterization should be made. If the bladder can be entered and only a small amount of bloody urine is obtained, it is possible that the bladder is ruptured. The next step is to inject a small amount of air which is done with less danger of spreading infection than with a roentgenographic medium. The roentgenogram will usually show when the air is not in the bladder and whether it has escaped into the peritoneal space or the retroperitoneal space. If in doubt, make an exploratory incision.

Rectal examination checks pelvic peritoneal irritations from blood or spilled contents of the hollow viscera. Blood found on the examining finger indicates injury to the lower intestine. In retroperitoneal rupture of air-containing viscera, emphysema of the pelvic tissue may be palpated.

Laboratory

Under the old system of relying upon frequent blood counts and hemoglobin estimations, we were not able to distinguish with accuracy variance in red cell changes, while with the more recent system and practical application, frequent checking of the specific gravity of the blood and the cell plasma percentage, one can definitely estimate the trend of the change in the blood picture to a degree many times as sensitive as the older method.

The crucial test of surgical judgment occurs when the surgeon is confronted with unmistakable signs of combined shock and hemorrhage.

Anesthetic

Ether is the anesthetic of choice; it gives relaxation and very little shock. Spinal anesthesia causes too much drop in blood pressure, which is already at a dangerous low level. Also, it may cause contraction of the intestine forcing more of the intestinal contents out into the abdominal cavity. Some surgeons maintain that if a patient is in shock, treat the shock first, even before a diagnosis of the lesion has been made. If there is anything that should not be done, it is to treat shock before you know what has caused it. Shock may be caused by hemorrhage or septicemia or may be psychic. Note the patient's condition when in shock. The pulse is fast and thready, the respirations are rapid and shallow, the blood pressure is subnormal. Hemorrhage, if present, will decrease or even stop as long as shock persists. Shock may be one of nature's methods of defense. Now, what occurs when shock is treated by stimulants in a case of hemorrhage? It is increased unless the bleeding has been checked by ligation

or packing. Death is often caused by secondary hemorrhage.

We should not give a blood transfusion in a suspected hemorrhage unless the patient is on the operating table, not before.

Every surgeon should have a definite method of procedure in these cases. Make a wide exposure, then examine the liver. If ruptured, use pressure. Then insert mattress sutures and, if necessary, a pack to control bleeding. Then examine the stomach, spleen and kidneys. Next begin with the duodenum and follow the small intestines down to the cecum. Lift the great omentum and the stomach and examine the posterior parietal peritoneum. If the peritoneum is elevated or bluish at the origin of the mesocolon, one often finds a rupture of the duodenum. Look for mesenteric tears, then end up with a thorough examination of the entire colon. With such a procedure little is missed. In this type of surgery every stitch counts; not one can be left out. To secure speed the operator should not sacrifice thoroughness. All perforations should be closed with a purse string suture if possible; if not, I use the buttonhole stitch or mattress suture. I use the suction machine. If the patient's condition is good, and resection is necessary, I use the closed method; if his condition is not good, I exteriorize. I avoid drainage if possible. I believe the sulfonamide group of drugs is of value.

Summary

1. The earlier the patient is operated on, the greater is the chance for recovery.

2. Irrespective of organs damaged, the amount of hemorrhage is the greatest single factor in mortality.

3. Shock and hemorrhage account for the greatest number of deaths.

4. The mortality increases with the decades of life.

5. The importance of diagnosis and methods of examination are considered. Treatment is reviewed.

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Lest We Forget*

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THE acquirement of medical knowledge is tedious, hard and never ending. Inspiration of leadership is necessary. We should all ever be students of the masters. Fortunate are those who have been privileged to study with them. But not forbidden or lost to others is the opportunity of appreciation of their lives. Contributions of truths are everlasting. The stimulus and guidance of their wisdom are available to the student who seeks them. Medicine, being a science, leads from truths to speculations to uncertainties. Values of truths may be lost in their simplicity. Seekers of knowledge

* William Snow Miller Lecture, University of Wisconsin. Delivered March 13, 1941.

may be overwhelmed with facts for lack of vision. The student must learn to find facts and build upon them. Let us, as students, be not likened to the two workers in the quarry, one of whom was shaping stone and the second one cutting marble, but rather to the third one who, when asked what he was doing, answered, "I am building a cathedral." Accumulate the truths, but always with vision. Furthermore, be not lost in the business of accumulation, but seek also to contribute. A man is not worthy of his profession who seeks only to gain and not to give. Follow the man we honor.

Diagnosis Must Be Complete

Diagnosis of any lung disease is not correct unless it is complete. To be complete the diagnosis must comprehend accurate anatomic localization, extent and pathologic description of the lesions. A diagnosis of pulmonary tuberculosis based only on the finding of tubercle bacilli in the sputum is almost useless for prognosis and treatment. The lobes involved and the extent and character of the lesions must be stated. Likewise, the etiology of lesions, whether inflammatory, new growth or anatomic malformation, must be understood. One or all of these changes may be involved, and the significance of each must be appreciated. Dilated bronchi alone are only an anatomic malformation. But, dilated bronchi plus infection constitutes the clinical disease bronchiectasis. The embryologic development of the lung and bronchi may hold the answer of later disease. At birth the lungs are in fetal state with alveoli uninflated and bronchi partially patent. It is to be remembered that some alveoli may and do remain uninflated for a variable time after birth. It has been estimated that areas of fetal lung may exist in an individual up to twelve or fourteen years of age. Some alveoli may, by developmental mishap, never inflate. Some areas of lung may fill out and later recollapse. Certain bronchi may not follow the normal growth of the rest of the lung, or may be impeded in their development by enlarged lymph nodes leading to atresia. Such disturbances of development afford the setup for later predestined diseases of bronchiectasis or cystic disease.

When you open the thorax and expose the lungs, you find them collapsed and sunken into the posterior depressions of the thoracic cavity. But this is not the living anatomy of elastic organs, suspended by a loose musculo-fibrous suspensory apparatus from the base of the skull, free to move in a large space divided by a mobile mediastinum. These are structures normally free to adjust themselves to distortion and dislocations from disease. The carina of the trachea, little observed in dissection, located at levels varying from the second dorsal vertebra in the fetus to the fifth dorsal body in the aged, is a landmark in clinical study of the chest. The angle of this bifurcation may give us the clew to a tumor or enlarged lymph nodes producing widening or an enlarged left auricle of the heart pushing up the left bronchus. Cartilages studied in infinite detail as to shape, size and position by sections and models seems a subject purely morphologic. But, the patency and shape of the air tube is explained by these structures. Interference of development or erosion by disease of the cartilage alters the pathway of the air so vital to the function of the lungs. A bronchus with its cartilaginous wall, viewed on cross section near the hilus on chest roentgenograms, has not infrequently caused misinterpretation of small cavity in the lung. The size of bronchus where cartilage is lost also marks the level where the smooth muscle in the wall changes in distribution from regular bands to scattered fibers. Smooth muscle in the bronchi is a microscopic study, but loud and emphatic in clinical assertion. Listen only to the wheeze and stridor, or watch the physical struggle of an asthmatic patient, and then ask where is smooth muscle and how does it act. Normally designed to function for the protection of the air cells, the terminal band of this smooth muscle, encircling like a sphincter the opening of the atria, can be thrown into such contraction as to produce internal suffocation. The action of smooth muscle relaxing drugs in such states is close to miracle in medicine.

Interference of normal drainage of the bronchi with resulting stagnation of secretions and weakening of the wall leads to dilatation. The earliest evidence of such bronchiectasis is detected and described as small herniations of the mucosa between the strands of smooth muscle and scattered pieces of cartilage. The most frequent site of such early bronchial dilatation is in the long lingual tip of the left upper lobe, a bronchus with normally poor drainage because of its shape and length. The significance of bronchiectasis complicating other chronic lung diseases is extremely important. Almost invariably it accompanies long standing chronic fibroid pulmonary tuberculosis. It is in such cases that we most frequently note at post mortem the earliest evidence of dilatation in the lingual tip bronchus. Such patients may continue to have cough and expectoration with bloody sputum and even hemorrhage long after the tuberculous lesions are fully arrested. These symptoms are the result of the accompanying bronchiectasis. It challenges the acumen of the finest clinician to distinguish between this cough, sputum and blood which the patient may continue to have, and the same symptoms which the patient presented when the tuberculosis was active. To the patient once having suffered from active pulmonary tuberculosis, such symptoms as cough, sputum and blood mean more tuberculosis, and it requires the positive, emphatic assurance of a good clinician to dispel his fears.

The lungs are, no doubt, submitted to as much or more insults from environments of living as any other organs. The air we breathe, varying in temperatures from 40 degrees below zero in Madison winters to 109 degrees air-conditioned Cincinnati summers, always well stocked with either the clean dust of the country or the added city advantage of soot, and never free from rich pollution of bacteria, needs much preparation for healthy consumption by the body. The cilia of the trachea and bronchi do much in this protection. In the finer bronchi this is lost, and the columnar epithelium changes through the transitions from cuboid to flat squamous continuous single layered epithelium of the alveoli. For us the description, continuous single layered epithelium of the alveoli, has been emphasized. Why the emphasis? Because spaces or pores between the lining epithelial cells of the alveoli would allow of ready contiguous spread of serum or cells from one alveolus to another. Our thoughts of pneumonia, edema, or even normal physiology in the lungs would be influenced by such a concept. It is proven they do not exist.

Importance of Lymphatics

Most important of all protective mechanisms for the lungs supplied to us are the lymphatics. Most valuable of all anatomic descriptions for use in study of diseases of the lungs is that so classically given to us of the lymphoid tissue, the lymphatics and the circulation of the lymph. Can you comprehend lungs normally possessing no lymphoid tissue? Not too long ago, the presence of such tissue in these organs was looked upon as pathologic. Not only has the normal presence of lymphoid tissue in the lungs been demonstrated by investigators, but our peculiarly rich heritage is also an exact knowledge of the position and amount of lymphoid tissue in the form of nodes or masses, the location of lymphatic vessels in bronchi, arteries, veins, septa and pleura, the identification and placement of valves in these vessels and a complete comprehensive description of the normal flow of lymph in lungs and pleura. The size, position and structure of lymph masses at hilus and along the bronchi allow us to interpret properly the shadows produced by them on chest roentgenograms. The absence of lymphoid tissue and lymphatics beyond the ductuli alveolares pulmonis forces us to include in our concept of pathologic changes the part played by the wandering phagocyte. View this cell laden with coal pigment bearing its load to depots of lymphoid tissue for deposit in cases of anthracosis, and you see the action of phagocytosis. These same cells can and do grab bacteria such as tubercle bacilli and conduct them to the realm of the lymphatics. Tubercle bacilli so engulfed in the cell can be stained and recognized. The phagocyte can carry this

organism but not destroy it. It remains for the lymphoid cells to attempt this destruction. Even this roving scavenger cell of the lung challenged the interest of our investigator and caused him to speculate and question its origin, be it endothelial or mesothelial.

The understanding of normal lymph flow from the parenchyma of the lung to the hilus lymph nodes makes us reason that infection does not spread from the hilum out into the lungs, but from the lungs to the hilum. The placement of valves in the septa at the pleura, with the consequent area of drainage toward the pleura, explains for us the open pathway allowing of infection passing from the lung beneath the pleura to this membrane. The presence of valves opening toward the hilum in the inner third of the lung makes obstruction of flow in this area give rise to the peculiar clinical picture of lymph stasis and edema localized to the inner third zone of the organ. The characteristic roentgenogram of symmetrical bilateral butterfly-like pattern in the central lung fields in cases of uremia is an unexplained but striking example of this condition. The pathognomonic roentgenogram findings of a Ghon in the parenchyma of the lung, the heavy trunk marking leading to the hilum and the calcified lymph node in the hilum are mute evidence of primary type tuberculous infection and the residual permanent localized scars wrought in the lymphatic system of the lung by Koch's phenomena in the human. Bear in mind the presence and position of lymphoid tissue in the chest, and the clinical pictures of lymphoblastoma, Hodgkin's disease and leukemia will be simplified.

Roentgenograms

The lungs lend themselves to study in the living by chest roentgenograms perhaps better than any other organ. Anatomy has been taught to us by dissection of the dead. Now in our modern progressive anatomic laboratories the roentgenogram augments dissection and presents to the student that study in the living. Lung pathology was taught to us by study of organs removed from the body, but now the investigator of lung diseases is viewing his postmortem findings largely as confirmations of his observations and predictions made from study of the roentgenogram. The trained observer is able to study disease in the lungs as a scientific problem in its own unfortunate living host. To do this he must first be able to recognize the normal and interpret the densities in terms of anatomic structures and tissues, or pathologic changes. The knowledge of the branches of the bronchi to the lobes and their divisions within each lobe allows us to view these structures on the roentgenograms and thus accurately localize the lesions of disease. Only by such exact studies can surgery of the lungs be practiced. The position of an abscess, the location of a cavity, the limitations of an encapsuled fluid, the circumscribed borders of a tumor determine for us the possibilities of surgical approach. A lesion correctly located in the apex of a lower lobe, instead of incorrectly placed in the hilus region or another lobe, may determine the prognosis or completely alter the planned treatment of the case. The trunk markings seen on chest roentgenograms are produced by the composite densities of bronchus, artery, accompanying lymphatic vessels and surrounding connective tissue. Anatomic studies by injections of blood vessels, serial microscopic sections, wax models, and corrosion specimens still standing on the shelves show us that the pulmonary artery closely accompanies the bronchus in all of its divisions. It lies posteriorly and slightly lateral to the bronchus. Engorgement or thickening of the arteries results in widening of the trunk markings on the roentgenograms. More and more we are appreciating the importance of sclerosis of the pulmonary arteries in emphysema, chronic lung inflammation, silicosis, cor pulmonale, Ayerza's disease, and we welcome any means to help in its recognition. The enlargement of the pulmonary conus or arteries at the hilum may determine our clinical diagnosis of cardiac disease or disturbed pulmonary circulation. The position of the pulmonary artery close to the bronchus helps to answer the comparatively rare finding of Rasmussen's aneurysm in

the wall of a cavity. We find that this develops when the artery approaches the wall of the cavity tangentially. The discovery of this rupture at post mortem has solved for us several cases of death by hemorrhage. The bronchial arteries, a part of the general systemic arterial system, beautifully and proudly demonstrated in many ways by slide and model, occupy no secondary place in clinical considerations. Hemorrhages in bronchiectasis are often most profuse, persistent and hard to control. The bleeding is from the bronchial artery. This vessel is embedded in the rigid cartilaginous wall of the bronchus and is less apt to contract and be closed. It is a part of the general systemic circulation where the pressure is higher than in the pulmonary circuit. There are few bronchial veins. The nutrient blood supply is returned almost entirely by the pulmonary veins. Anastomosis between the bronchial and pulmonary arterial systems does occur and has been demonstrated. The reminder of the bronchial arterial system makes it possible for us to explain paradoxical emboli and infarcts in the lungs and interstitial hematogenic chronic miliary tuberculosis, a condition we are observing more frequently in clinical studies and at the autopsy table. Careful injections of both bronchial and pulmonary arterial systems show that the distal portion of the divisions of the bronchi, namely the ductuli alveolares pulmonis and air spaces beyond, receive their nutrient supply from the pulmonary vessels. In these distal areas there is union of capillaries formed from the bronchial and pulmonary arteries. Tubercle bacilli seeded into the lung by hematogenic route are particularly prone to lodge here and form lesions. The keen observation of the fact that the bronchial arteries in the human and guinea-pig supplied the lymphoid tissue in the lung, but that in the rabbit the lymphoid tissue gained its nutrient blood supply from the pulmonary artery, led to the explanation and correct interpretation of a critical series of animal experiments. Is anatomy only morphologic? It is, only if you make it so.

Demonstration of Reticulum

The interstitial framework of the lung is made up largely of fibrous connective tissue. This occupies the space between bronchi, blood vessels, lymphatics and alveoli. It is the binding part of an orderly made structure. In the healing of chronic lung diseases there is production of new fibrous tissue in the form of scar. Especially in chronic fibroid pulmonary tuberculosis the formation of this fibrous tissue may be very extensive. Its presence in excess disturbs the normal orderly pattern of the lung structure and may seriously interfere with the function of the organ. In the wall of the alveoli and throughout the entire framework of the lung forming a basement membrane for cells, reticulum is found. Delicately stained slides made from microscopic tissue sections of chronic fibroid tuberculosis show that reticulum was early laid down in the formation of scar and then followed by collagenic fibrous tissue. This demonstration of reticulum is only another one of the difficult technical procedures characteristic of the hand of the master. Fibrous tissue, when once developed in a lung, never absorbs and remains as a permanent scar ever visible on the roentgenogram, unless ulceration or cavitation removes it from the area. But it is noted with sharp distinction that in areas where formation of caseation is predominant that there is little or no reticulum developed, and no fibrous scar tissue results. Hence caseation can absorb and its disappearance noted and studied on the roentgenograms. This is a relatively new observation because it was formerly thought and taught that caseation once developed in the lung could only proceed to the changes of destruction and never be absorbed. Such observation has greatly changed our prognosis in caseous bronchopneumonia. It indicates that tuberculosis can heal both by formation of scar tissue and by absorption of exudate and caseation.

In addition to reticulum, there are two other types of connective tissue fibers, collagenic and elastic. Collagenic fibers are most abundant. They are arranged in

bundles or spread into membranes and resist unequal pressure or stretching. They form the bulk of scar tissue formed in the healing process of inflammatory disease. Elastic fibers branch and anastomose. They form networks which are capable of stretching and resuming their normal size and position. Elastic fibers are recognized in sputum and, when so found, give evidence of destruction of lung tissue. These fibers are demonstrated in tissue slides by special stains and then show beautifully the part played by them in the architecture of the organ. The walls of the alveoli are abundantly supplied with these elastic fibers. Sections of lung tissue stained especially for the elastic fibers, leaving out cells and the other connective tissue, show a honeycomb-like framework of the sacculae and alveoli. In normal respiration these air cells and also the bronchi expand and contract. In emphysema we find the air cells overdistended. The framework of the sacculi and alveoli is stretched. When the emphysema is severe and general throughout both lungs the organs are enlarged, and the chest cavity in turn is increased in size. Finally, we have the clinical picture of the deep chested, stooped, cyanotic, distressed patient, struggling to force air out of the overdistended air cells where rapid exchange of gases is so imperative. Under the microscope we see the picture of alveoli more and more stretched, pulling and elongating the elastic fibers in their framework. Finally, the stretching is overdone, elastic fibers snap, walls give way and bullae of large spaces form. These bullae in the lung may reach proportions in size so as to be mistaken for cavities on chest roentgenograms. But more interesting is the phenomenon of interstitial ephysema. In such cases the stretching of air cells, snapping of elastic fibers and separation of cells lead to rupture of the continuous lining membrane and escape of air into the interstitial connective tissue of the lung. This air dissects its way along the bronchi or blood vessels toward the hilus and may make its appearance in mediastinum, neck or soft tissues over the chest wall. The clinical picture is sometimes difficult to recognize but, when detected, is striking in its signs. The patient is struck with sudden pain in the chest and then becomes either short of breath or aware of a peculiar distress with respirations. The physical examination at first may show nothing, and you are baffled, which is not new or strange in medicine. But later you are amazed in percussing the chest to feel moving, crackling (the kind that can be felt), firm bubbles of air under the skin of the neck or upper chest wall. More startling is the detection of the air bubbles in the mediastinum or lung framework by the crunching, crackling sound of egg shells breaking synchronous with the heart beat. It tells of air let loose in the connective tissues by rupture of the limiting membranes of epithelium and elastic fibers.

Visceral Pleura

The visceral pleura consists of four layers, named from the outer to the inner in order, mesothelial, submesothelial, elastica external and areolar. The elastic layer stands out in tissue sections properly stained as one of definite compact fibers. Another layer of elastic fibers, called elastica internal, just above the alveoli has been described. But, tissue sections and photomicrographs preserved for us show that these internal elastic fibers belong not to the pleura but properly to the alveoli. The fibers are continuous and anastomose with those in the walls of the underlying air cells. This seems a point of ultra fine distinction, but none too meticulous for the anatomist looking beyond the tissue slide. Rupture of these elastic fibers joining outer alveoli and pleura also occurs in emphysema. The escaped air dissects outward in the pleura, invading the areolar layer and separating the membrane from the lung surface. This leads to the formation of blebs which may reach enormous size and lead to confusion with cavities or cysts in the lungs. Hard to explain is the fact that an entire lobe may be honeycombed with cavitation, or reduced to a single large sack with destruction of all lung structure, and the pleura remains intact. On the other hand, spontaneous

pneumothorax suddenly occurs, and there may be no demonstrable lung lesion or at the most some emphysema. A logical thought of reasoning is that, in the former case, the inflammatory process waging destruction in the lung is resisted and held in check in the pleura by the efficient defense of elaborate lymphatic drainage plus the natural toughness of the membrane. In the latter case, an anatomic weakness inherent in the structure of areolar layer and elastic fibers allows of sudden rupture with overdistention of the air cells. In fact, primary general pulmonary emphysema in many cases, where the element of scar tissue formation due to inflammation, silicosis, or new growth is present, can be eliminated; where there has been no bronchial obstruction, and where the patient cannot be acclaimed or accused as a trombone player in the band, the case must rest on a premise of congenital structural weakness in its fibrous supportive network, allowing of overdistention under comparatively normal conditions of respiration. The disabling factor of emphysema does not remain confined to the faulty air flow into and out of overdistended air cells. The tiny pulmonary arterioles compressed between the enlarged sacculi become thickened and sclerosed to a degree sufficient to damage and embarass the right side of the heart. Emphysema, pulmonary sclerosis, chronic cor pulmonale are factors and progressive events with which we must reckon seriously in judging disability, prognosis, or advisability of surgical measures in chronic lung infections.

Structure of the Septa

Septa are prolongations of the areolar fibrous tissue of the pleura extending into the lung and dividing it into the arbitrary units of secondary lobules. The structure of these septa, compact with areolar tissue and containing elastic fibers with blood and lymphatic vessels embedded in them, makes them comparable to the resistant layer of the pleura. Their resistance to the progress of inflammation by contiguous spread is similar to, but not as great as, that offered by the pleura. Exudate of early pulmonary tuberculosis will be stopped by the septa, accounting for the sharply localized physical signs and characteristic densities as seen on chest roentgenograms. But ulceration and cavitation in their destructive extension break down and through the septa. Any extension of cells into the lung tissue, be it a tuberculous process, an acute lobular pneumonia or infarct can be localized and confined by these connective tissue barriers. The triangular lesions of an infarct viewed grossly or microscopically in the cut lung are limited by the septa. Likewise, it is not unusual to see areas of severe emphysema or a bulla stopped by these same fencelike bars. New growths in the lung, on the other hand, are little impeded in their relentless contiguous growth and move on to whorls and nodules in size, outreaching the confines of the secondary lobules. There is another interesting phenomenon observed grossly at the postmortem table which illustrates vividly the lymph flow in the septa. Areas showing enlarged full lymphatic vessels will be seen in the pleura. Make a cut into the lung immediately under this spot, and you will find a fibrous lesion, perhaps not even reaching to the pleura, but placed in the midzone of the lobe. Microscopic studies will show that the normal lymph flow from the midzone of the lung toward the hilus has been obstructed by distortion of the septum with scar tissue forcing more than the normal amount of flow of lymph to the pleura in this area. The valves placed in the lymphatics at the junction of septum and pleura open toward the pleura. We were shown this by the slides, and nature affords us a demonstration.

The nerve supply of the lungs is from two sources; namely, the vagi and the sympathetic nerves. The completed picture of their distribution is still forthcoming but promised by inspired investigators. We are shown that ganglia occur along the nerve fibrils in the bronchi and blood vessels, and that special end organs are placed in smooth muscle fibers. Microscopic studies made in cases of emphysema and chronic bronchial infection show infiltration of the tissues by the telltale eosinophils of asthma, and strik-

ingly the ganglia themselves are invaded. Seldom do we stop to consider why it is that we see a lung partially or completely destroyed by tuberculosis, abscess or new growth, and yet the patient has no pain. How often we wish that tuberculosis in the lung did start with pain so that the affected person might be stimulated early to seek medical advice, rather than wait for the subtle onset finally to culminate in hemorrhage or positive sputum. On the other hand, one only has to be visited by a localized beginning pleurisy in order to be informed of it by excruciating pain. Witness a patient comfortable and free of pain with both lungs full of metastatic carcinoma, and contrast him with another suffering individual struck by pulmonary embolus with a small lesion in the lung capped by a localized pleurisy. The lungs have no pain nerves; the pleura is rich with them.

A diagnosis to be correct must be complete. Treatment to be effective must comprehend etiology, appreciation of the pathologic changes which have occurred, together with distortion and destruction of anatomic structures, understanding of how the lesions may progress and vision of nature's defense against disease with ability to heal. Clinical medicine embraces the study of anatomy and physiology of the human body and all environmental factors which tend to distort them from the normal. The lungs are delicate and complex in structure, vital in function and fortunately well defended from environmental insults. But, disease in them is common. Well planned it is that a person has nine times more lung than he needs to sustain life in the body. Else, how could one whole lung and part of another be consolidated with pneumonia or destroyed by cavities? How could one entire lung or parts of both be compressed intentionally by pneumothorax or thoracoplasty? Reduce the functional capacity in one part, and you increase it in another. Disease is the battle of the body to function normally against the efforts of environment to alter such performance. Anatomy of the lungs as studied, taught, investigated and described for us points the way to understanding of the battles in these organs.

Compiling, teaching and treasuring medical history, he preserved it for us and those who are to follow. Riches were counted in books, manuscripts, brochures, monographs, charts, pictures and lines gathered from the ages. He not only collected, he made medical history. Questioning the teachings of those gone before, criticizing severely but justly and constructively the writings of others, praising and giving credit where it was deserved, he presented the new with conclusiveness and authority. Atria, ductuli alveolares pulmonis, lymphoid tissue, lymphatic flow, blood vessels, connective tissue fibers, nerves, primary lobule, what are these but functioning anatomical units, building stones of the lung? But more, their descriptions are self-made, everlasting memorials to William Snow Miller, building stones in the temple of medicine.

A combined lecture and demonstration course in Occupational Dermatoses will be conducted in Chicago, beginning January 11, 1943, by Dr. Louis Schwartz, Chief of the Dermatoses Investigations Section of the U. S. Public Health Service of Bethesda, Maryland. The teaching period will cover two weeks, the first of which will be devoted to lectures and demonstrations, and the second to plant visits. Dermatologists, industrial physicians and others interested in the course should communicate with

Dr. Edward A. Oliver
55 East Washington Street
Chicago, Illinois

No limit will be placed upon enrollment for the lectures, but the visits to the plants will be limited to twenty-four enrollees. No fees will be charged.

Comments on Treatment

Editor—A. J. QUICK, M. D., Marquette University, Milwaukee

Papaverine in Heart Disease

Papaverine, although one of the opium alkaloids, has none of the narcotic or other characteristic properties that one associates with this group of compounds. Even in relatively big doses, it has little effect on the central nervous system; it has only slight hypnotic action and is a poor analgesic. It possesses the ability to relax smooth muscles, particularly of the blood vessels, and this appears to be its most important pharmacologic action. However, only recently has papaverine been recognized as a potentially useful drug, and only limited references can be found concerning its use in therapy. Favorable results have been obtained in pulmonary embolism, in peripheral vascular occlusion and in Raynaud's disease.

It has been demonstrated experimentally in dogs that papaverine increases coronary blood flow. This suggests that the drug should be useful in angina pectoris. Recently Elek and Katz[1] have reported favorable therapeutic results with papaverine in anginal attacks. They employed relatively large doses —1½ grain (0.1 Gm.) orally, four times a day. In a small series of cases, they obtained favorable results in 70 per cent of their patients. Previous reports on papaverine have not been as promising, but it may well be that inadequate amounts were administered. The patients of Elek and Katz, when given this drug, had fewer attacks, less pain, and usually increased their walking capacity very definitely.

[1] Elek, S. R., and Katz, L. N.: Some Clinical Uses of Papaverine in Heart Disease, J. A. M. A. 120: 434 (Oct. 10) 1942.

The same authors also found that papaverine had an effect in reducing, and even in abolishing, premature beats of ventricular, nodal or auricular origin. To obtain this effect a large dose of the drug was required—as high as 3 grains four or five times a day. Apparently no toxic action other than marked sleepiness was observed; but as pointed out by the authors, it is wise to use the smallest dose that will produce the desired result.

Papaverine appears to act on the conducting system depressing auriculoventricular and intraventricular conductivity. Its action is akin to that of quinidine, and Elek and Katz go so far as to suggest that it may be superior to quinidine in some respects. The two drugs can be given simultaneously, and papaverine therapy can be initiated when quinidine produces toxic action or fails to bring about improvement in the cardiac condition. Papaverine appears to have one advantage over quinidine, for in addition to its action on the conducting system, it is a coronary dilator.

The fact that papaverine is obtained from opium causes one intuitively to feel that it is very toxic and habit-forming. But the contrary is true. The large doses employed by Elek and Katz produced no undesirable results, and no idiosyncrasy was noted. It has long been known that papaverine does not cause addiction. The relative safety of this drug should warrant extensive trial, especially in supervised cardiac clinics. However, it is well to remember that many more clinical studies of this drug must be made before its status as a cardiac drug can be firmly established. A. J. Q.

New Ambidextrous Surgical Glove

Good news for hospital officials, charged with keeping up supplies of surgeons' gloves under present conditions, is contained in an announcement by The Pioneer Rubber Company of a new rubber saving stock reducing glove which the manufacturer calls "CONSERVOR." Skillfully designed to fit either hand with the comfort and freedom demanded in surgery, the facts that any two Conservors make a pair and that three sizes fit practically every operating hand mean welcome economies and cuts in necessary stock to hospitals—half as many sizes and pairs to stock, sort and have money tied up in. The manufacturer states that Conservors are made of finest quality pure latex, are very sheer and tough and stand a surprising number of trips to the autoclave.

THE NATION AT WAR

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Wanted: More Volunteer Nurses' Aides

By CHARLES S. HOFFMAN
Administrative Assistant, Medical Division, Sixth Civilian Defense Region

THE goal is far from being reached in the enrollment of Volunteer Nurses' Aides.

The number of students enrolled and the number actually certified and performing their work in hospitals is steadily growing but is still insufficient to meet the need for such service.

A number of factors have combined to increase the need for supplemental assistance in our hospitals, such as:

1. The congestion of population due to military mobilization and rapid growth of defense industries has overloaded the facilities of hospitals adjacent to such areas.
2. The shortage of priority materials has delayed or prevented the physical expansion of hospital facilities.
3. The use of approximately 45,000 nurses for assignment in the Army, together with the attraction to defense industries of personnel which formerly might have taken nurses' training, have caused serious personnel shortages in a growing number of hospitals. In addition, nurses are being called by other services, such as the Navy, Marines and U. S. Public Health Service.
4. The withdrawal of approximately 52,000, or about one-third, of the physicians from private practice for work in the Army means that the remaining physicians must necessarily turn more and more routine work over to the nurses. This makes the procurement of additional nursing personnel even more urgent. Because of the longer training period for graduate nurses than for Nurses' Aides, this need can be met by increasing the enrollment of Volunteer Nurses' Aides.

The result of these and other wartime conditions makes it more imperative that the program of Volunteer Nurses' Aides be expanded to meet not a *future* need but a need which exists *today* in the hospitals of your community.

In the fall of 1941, the Medical Division of the Office of Civilian Defense initiated a program in cooperation with the American Red Cross for the enrollment and training of 100,000 Nurses' Aides. The results, while encouraging, have fallen far short of expectations. As the tempo of military activity increases, the need for nurses' aides becomes even more pressing.

In Wisconsin considerable effort is being expended on this program by Dr. R. E. Fitzgerald, Chief of Emergency Medical Service, Miss Mildred Fehlhauer, Nurse Deputy for Wisconsin, and officials of the American Red Cross. The work cannot be done entirely by official representatives of interested agencies, but must be carried forward by the members of each community who will accept responsibility for insuring adequate Nurses' Aide assistance in hospitals of their city or community.

Every woman, eighteen to fifty years of age, who can donate 150 hours of service in the wards of a hospital during a three month period following initial training, and 150 hours service annually thereafter as assigned, should be encouraged to offer her services. Application may be made at the local office of Civilian Defense or local chapter office of the American Red Cross.

Following satisfactory completion of the eighty-five hour course at designated hospitals, the trainees are inducted into the U. S. Citizens Defense Corps and are authorized to wear the sleeve and cap insignia identifying them as Volunteer Nurses' Aides. As members of the Citizens Defense Corps, Nurses' Aides will normally be on call for emergency service in hospitals, or in casualty

stations as members of the emergency medical teams. Personal qualifications and family responsibilities will be taken into account in determining the type of duty for which Nurses' Aides are to be called. The duties of the Volunteer Nurses' Aides will be to assist the graduate nurses in order to free them for those services which only the graduate nurse can do. Many of the time consuming tasks formerly done by graduate nurses can be competently performed by Nurses' Aides.

If they have not already done so, the responsible leaders in each community should survey the available facilities and personnel, the possible depletion of present personnel, and then analyze the apparent need for Volunteer Nurses' Aides. They should then apply every effort to obtain adequate nursing services for domestic needs in homes and hospitals, and for possible use in caring for civilian casualties resulting from enemy action. It is the least we can do for the maintenance of public health and morale on the home front.

WANTED: More Volunteer Nurses' Aides!

Nurses' Aides in Wisconsin

By MISS MILDRED FEHLHAUER
State Nurse Deputy, Emergency Medical Service

THE demands made upon the nursing personnel in Wisconsin have resulted in an acute shortage of trained nursing personnel in many sections. The exact number of Wisconsin nurses who have joined the armed forces cannot be disclosed. The nurses who remain at home have met the full brunt of the load which has been placed upon their shoulders. It has been a case of more work and fewer nurses.

To alleviate this strain, the Office of Civilian Defense and the American Red Cross have combined their efforts and evolved a program to train Volunteer Nurses' Aides. These aides are trained to be the nurses' helpers. This strain has been partially relieved in the many Wisconsin communities that have already inaugurated and received the benefits of this plan. There are, at the present time, thirty-three hospitals participating in the training program. Upwards of 800 Nurses' Aides have already been graduated in our state. Approximately one-half of these received their training in Milwaukee hospitals.

NURSES AIDES CORPS

Only one-half of the eligible hospitals have inaugurated this program in their institutions. An accelerated effort will be made in the next few months to institute the Nurses' Aides training program in the thirty eligible hospitals not currently participating. To effect the installation of a training program in these hospitals, the American Red Cross, The Wisconsin Council of Defense, the Nurse Deputy to Dr. R. E. Fitzgerald, Chief of Emergency Medical Service, the Wisconsin Hospital Association, the Bureau of Nursing Education, and the Wisconsin Nursing Council for War Service have all pooled their efforts.

Physicians in the state are urged to advise and counsel our hospitals in the establishment of Nurses' Aides training in their communities in order that the effects of the nursing personnel shortage may be mitigated.

The Nurses' Aides are not substitutes for regularly and fully trained nurses. They make it possible for the nurses to spread their services more widely by relieving them of such tasks as making beds, giving baths, taking temperature, pulse and respiration. They also assist in applying casts and slings, giving evening and morning care to men, women and children, and performing similar duties.

In exchange for the service and facilities of training, the hospital receives during the initial training period forty-five hours of supervised assistance; then each year thereafter the hospital receives a minimum of 150 hours of gratuitous services by the Nurse's Aide graduate. It is the goal of all interested agencies that every eligible hospital will co-operate in the program. One of the requirements of the American Red Cross is that there shall be a minimum of twenty-five beds in the hospital before it shall be eligible for the training program. Therefore, the small hospitals, as well as the larger ones, have a patriotic and community responsibility to effect the completion of the program in their institutions.

In the final analysis, it is the individual community which is the beneficiary of the program. Those who meet the qualifications and complete their training are essentially "home people" and form a stable reservoir for auxiliary aid to the community.

Those physicians and hospitals desiring to inaugurate the program should first approach the county chairman of the American Red Cross in their community in order that a subsequent conference can be arranged with the hospital, American Red Cross officials and the Nurse Deputy for the Emergency Medical Service program. Assistance in enrollment may be obtained from the Wisconsin Council of Defense and the local County Council of Defense.

Gasoline Rationing

THE following self-explanatory bulletin, issued by Don T. Allen, State Director of the Office of Price Administration, was sent to all local War Price and Rationing Boards in explanation of the bulletin issued by the State Medical Society to its entire membership. The certificate, incorporated in the bulletin, constituted sufficient evidence to the local boards that the person presenting same was a licensed physician.

Mileage Bulletin #7
Subject: Physicians
Date: November 6, 1942

Office of Price Administration
161 West Wisconsin Avenue
Milwaukee, Wisconsin

To All Local War Price and Rationing Boards
Staff
District Administrators

After conferring with representatives of the State Medical Society of Wisconsin and the Medical Society of Milwaukee County, I have approved a letter which those Societies are sending to all of their members outlining the gasoline rationing procedure as applicable to physicians. I enclose two copies of this letter. I believe it is correct upon the basis of the information which we have at the present time, except for the new registration dates, but, of course, any changes which may be announced subsequently may affect the information given. In case of conflict, the Regulations, Guides, and Memos are controlling.

I call your attention to the certificate on the top of the first page of this letter, which the Societies have designed to be of help, both to the physicians and to you. When these letters are mailed out, the particular doctor's name will appear in the certificate, and I feel that such certificate will be satisfactory evidence that an applicant is a licensed physician or surgeon.

I wish to call your attention, however, to two facts in this connection:

1. The fact that an applicant is a physician does not necessarily entitle him to any supplemental gasoline ration. If he applies for more than an "A" book, he will also be required to show that he uses his automobile for purposes mentioned in the Regulations and the amount of mileage in the respective uses.
2. There may be duly qualified physicians and surgeons who are unable to offer the certificate of the State Medical Society, and such an applicant should, of course, be permitted to establish that he is a licensed physician or surgeon by showing other evidence such as his license, a certified copy thereof, or a certificate of the County Clerk of the County of his residence that such a license has been duly recorded.

I have also approved a Bulletin to be issued by the State Dental Society. No certificate is attached to the Dental Bulletin.

(Signed) Don T. Allen,
State Director.

New Method Invented For Field Administration of Morphine

The Office of Civilian Defense, in cooperation with the Office of the Surgeon General of the United States Army and the Schering Corporation, has invented a substitute for the tin syrette method of administering morphine. The new device is a small, sealed, glass ampule containing morphine in solution, with sufficient self-contained pressure to eject the entire contents of the ampule when the glass neck is broken within a piece of plastic tubing to which is affixed an expendable, steel needle.

The morphine is being ordered by the Office of Civilian Defense, through the Surgeon General's Office of the United States Army, in solution rather than in dry tablet form. The solution form was selected in order to facilitate the administration of morphine under field conditions, where it is virtually impossible to carry an adequate supply of sterilized syringes to prepare individual doses of morphine by the usual technics.

Final methods for the distribution have not been perfected, but are currently in the process of development. Further announcements on the distribution of morphine ampules for civilian defense purposes will be made in a subsequent issue of *The Wisconsin Medical Journal.*

RECENT WISCONSIN LICENTIATES

The following physicians were granted licenses to practice medicine in Wisconsin after passing the examination given by the Wisconsin State Board of Medical Examiners at the Hotel Pfister, Milwaukee, on September 16, 1942:

Name	*School of Graduation*	*Year*	*Present Address*
Boccella, John A.	Marquette	1942	Milwaukee Hospital, Milwaukee
End, John A.	Marquette	1942	U. S. Naval Hospital, New Orleans, Louisiana
Herrick, Walter A.	Marquette	1942	St. Joseph's Hospital, Denver, Colorado
Schwei, George P.	Marquette	1942	5324 West Beloit Road, Milwaukee

The following physicians were granted licenses through reciprocity:

Name	*School of Graduation*	*Previous Address*	*Present Address*
Gilbreth, Glen H.	Loyola	Illinois	1851 Addison Street, Chicago
Gutheil, Byron W.	Loyola	Illinois	Sun Prairie
Kelly, Martin J.	Loyola	Illinois	Statesan
Knox, Lawrence M.	Washington U.	Kansas	1821 West Wisconsin Avenue, Milwaukee
Mead, Franklin B.	Northwestern	Minnesota	120 West Gorham Street, Madison
Moody, Leonard W.	Rush	Minnesota	Minnesota State Sanatorium Ah-gwah-ching, Minnesota
Roberts, Sidney M.	Jenner	Illinois	311 Jefferson Street, Sparta
Smith, Rodger B.	Rush	Michigan	224 West Washington Avenue, Madison
Thoma, John W. R.	Washington U.	Missouri	University Club, Milwaukee
Thomas, Clyde O.	Illinois	Illinois	1821 West Wisconsin Avenue, Milwaukee
Willstead, Otterheim	Chicago Medical School	Illinois	Hillsboro

CHRISTMAS SEALS

That the battle against tuberculosis is being carried on in full fury is attested to by Wisconsin postmasters, who are reporting that Christmas seals decorate a large proportion of letters and packages going through the mail.

The year 1908 saw 2,509 of our Wisconsin residents die of tuberculosis. Last year there were 773 deaths from the same cause, although the population of the state is now about one-third larger. In other words, the tuberculosis death rate has been reduced from 109.3 per 100,000 population in 1908 to 24.5 in 1941.

However, tuberculosis is no respecter of persons, and no one is immune. Members of 773 families in which persons have died are not consoled by low death rates. Education, tuberculin tests, chest roentgenograms and proper treatment for those afflicted can practically wipe out tuberculosis as a serious health menace.

The Wisconsin Anti-Tuberculosis Association does not receive any revenue from any other campaign, organization or governmental unit. To protect your home from tuberculosis buy and use Christmas seals.

THE WISCONSIN MEDICAL JOURNAL

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Annual Subscription--------Three Dollars-Fifty Cents Single Copies--------Fifty Cents

Advertising Representative: Cooperative Medical Advertising Bureau, 535 North Dearborn St., Chicago, Ill.

Address all communications to THE WISCONSIN MEDICAL JOURNAL, Madison

Volume 41 DECEMBER, 1942 Number 12

OFFICIAL PUBLICATION OF THE STATE MEDICAL SOCIETY OF WISCONSIN

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« « « EDITORIAL » » »

The 1943 Blue Book

DUE to many reasons, chief among them being the difficulties in obtaining the latest information relative to several recently enacted laws, it has been decided that the January rather than the December issue of *The Journal* be the annual Blue Book edition.

In addition, it seemed somewhat more practical that the edition of current laws, regulations, and miscellaneous material be printed during the year for which it is intended to be of service. The forthcoming Blue Book will doubtless be the most complete issue yet printed. Besides the summaries customarily incorporated, new material relating to the physician in the wartime service of his country will be contained in a special section. A revised article on the subject of tax laws has been prepared. New material relative to various activities of the Society in medical-economic studies will be summarized, together with a wealth of material relating to everyday problems of the physician.

Watch for the Blue Book issue; it will be a valuable and handy source of reference.

The Same Goal Post

THE physicians of Wisconsin and the Women's Field Army are striving to attain the same goal, that of reducing the incidence and deaths from cancer and the alleviation of suffering resulting from the disease.

The physicians' means of attaining this goal is through early diagnosis and effective treatment. The means employed by the Women's Field Army is that of public education. The precepts of the organization are contained in the words that have come to be identified with the Women's Field Army and the American Society for the Control of Cancer—"Fight Cancer With Knowledge."

Permeating the Women's Field Army, we find the same ideals and many of the same ethics that pervade the medical profession. In all the educational work that is done by the Women's Field Army we find constant emphasis and repetition of the concept that only the accepted and proven medical procedures should be called upon by the public in the care of those afflicted with the disease; namely, surgery, roentgenography and radiumology. The same high plane of ideals is maintained by the Women's Field Army on the question of quackery in the treatment of those having cancer. The public is constantly warned against the danger arising from the employment of those who are incompetent and who prey upon the credulous sick.

Year after year there has been an uninterrupted devotion by hundreds of women throughout Wisconsin to the task of informing their friends and fellow citizens on cancer to the end that suffering and death may be reduced to a minimum. This devotion to the health of their fellow citizens is often passed over lightly by those who are not fully cognizant of the untiring efforts and long hours of work that are involved in carrying forward, in true crusade fashion, a program for human betterment.

In recognition of this devotion, the profession can do no less than to acknowledge and recognize a teammate which renders such valuable assistance in gaining the same goal post.

Dues For 1943

IN PRESENTING the recommendation of the reference committee of the House of Delegates that dues for 1943 be established at $29, Dr. Karl H. Doege, Marshfield, committee chairman, speaking for the entire personnel of the committee which included Drs. L. O. Simenstad, Osceola; Charles Fidler, Milwaukee; J. S. Supernaw, Madison; and Hugh M. Caldwell, Columbus, said:

". . . Your committee has surveyed the budget in detail and approves it as presented. An accurate survey of the probable membership for 1943 brings us face to face with the conclusion that the dues-paying membership will be about 1,800. If dues are maintained at $25, as they were this year, based on a membership of 1,800 a drastic curtailment in the activities of the Society will be required.

". . . At a time like this, it seems apparent to this committee that it falls upon those who are not in service to maintain the integrity of the State Medical Society of Wisconsin for those of our members who are in the armed forces.

". . . it is in great measure up to us to pitch and keep the Society intact for them when they return."

. . . . THE PRESIDENT'S PAGE . . . .

"E"

PUBLIC spirited effort beyond the call of duty and to an extent that could only be self-imposed merits the Army and Navy E pennant that flies over many industrial units of our country today. To those who have earned this signal mark of distinction, as well as to those who will receive it in the arduous months that lie ahead, go the grateful thanks of a people now fully cognizant of what an all out war effort requires.

Let us take stock, for a moment, of the work of the medical profession along these lines in Wisconsin. At the end of the first nine months of 1942, the medical profession in Wisconsin, as well as in forty-two other states of the Union, was advised by the Washington office of the Procurement and Assignment Service for physicians that the enrolment objective for 1942 had been met. Although active recruiting was discontinued for the balance of this year, certain of the younger element were advised either to initiate or to continue to process their applications for commissions. Certainly it can be said, "An 'E' to the doctors for their grand record."

Civilian Defense has enrolled hundreds of doctors in Wisconsin who have participated most unselfishly and efficiently in the developing of plans in the field of Emergency Medical Service, training not alone themselves but untold numbers of volunteers for that day, if it comes about, when Civilian Defense becomes a broad and active force in the protection of our country and its people. Again, an "E" to the profession and its splendid work, and for the work that will be given in the future.

In the administration of the Selective Service Act, the entire medical profession of America has participated generously and given freely of its time and its advice in aiding with proper physical classification of registrants. In Wisconsin, well over 2,000 physicians have served countless hours and without reimbursement in that patriotic effort. Again, an "E" to the profession for a grand job well done.

And so it is possible to go through the record of the medical profession in Wisconsin in war and in peace,—the postgraduate industrial medical and surgical clinic at Milwaukee; the spring postgraduate clinics held in Wausau, Fond du Lac and Chippewa Falls; the public health and scientific programs that were made available to the physicians at the annual meeting, the profession's ability immediately to respond in June of this year when it became necessary to provide hundreds of youngsters applying for work in the canneries of our state with physical examinations to ascertain their fitness,—these and many others have been the contributions of the medical profession in Wisconsin. Many more will be added during the months that lie ahead, and to the physician I say with conviction that lies deep in the heart that the medical profession in Wisconsin has not, is not, and will not be found wanting in its patriotic endeavors.

F E Butler

Postgraduate Industrial Medical and Surgical Clinic Enthusiastically Accepted

OVER 500 members and guests participated in the first Postgraduate Industrial Medical and Surgical Clinic presented by the Society in co-operation with the Industrial Hygiene Unit of the State Board of Health.

The physicians, as well as the guests, attending the clinic commented time after time upon the excellent scientific program and display of scientific exhibits. The registration and attendance at the meeting, held at the Hotel Schroeder in Milwaukee on November 17, surpassed the expectations of all.

The same fervor to obtain authentic and reliable information was evidenced by those attending this clinic as is usually evidenced at the spring clinics of the Society. Members attending the conference came early and remained for all of the topics.

A wide selection of scientific exhibits contributed materially to the scientific program. Throughout the day the exhibit hall was occupied with physicians studying the numerous displays.

Dinner Conference

Over 400 physicians and employers attended the dinner conference, held in the Crystal Ballroom of the Hotel Schroeder, to hear such outstanding authorities as Mr. Andrew T. Court, labor relations counsel for the General Motors Corporation in Detroit, and Mr. W. D. James, president of the Wisconsin Manufacturers Association and the James Manufacturing Company at Fort Atkinson. The presentations of these two outstanding speakers were supplemented by an address from Dr. E. R. A. Merewether, His Majesty's factory inspector, who discussed experiences in England.

Mr. Court's remarks dealt with both the problem of sickness absenteeism in industry and with absenteeism not associated with illness. In the latter category, Mr. Court placed such industrial absenteeism as that which follows or precedes holidays and that occasioned by continuous seven day employment. It was the opinion of Mr. Court that physicians, industries and government agencies had reached the conclusion that there was scientific basis for complete agreement with the religious precept that one day of rest in seven was essential to maximum production. With the increase in the number of hours of employment, without opportunity for cessation of effort and the attendant recuperation of rest, production volume decreased.

Mr. James declared that industry needed and desired the wholehearted co-operation, study and assistance of the medical profession to aid in maintaining a full force of American manpower on the job and to that end pledged the complete co-operation of Wisconsin employers. To quote from Mr. James's speech: "We are thankful to you of the medical profession for the wonderful progress you have made in treating illness and accident victims—in getting them back on the job as soon as possible with a minimum of suffering and disability.

"More and more we will need your guidance and skill in the proper placement of workers, rehabilitation of the disabled workers, and evaluation of work capacities of individuals whom we place on our payrolls as vacancies occur and as our war expansion continues."

So enthusiastically was the clinic received by those attending that requests were made to formulate plans at once for the presentation of similar meetings in other parts of the state. Especially enthusiastic were the employers and manufacturers who saw in the clinics a means and a leadership to assist them in solving an obstinate problem—an opportunity to increase still further the volume of war work by reducing the man hours lost as a result of industrial injury and nonoccupational sickness and injury.

LIST OF REGISTRANTS AT POSTGRADUATE INDUSTRIAL MEDICAL & SURGICAL CLINIC

Members

Abelmann, T. C. H. — Watertown
Adamski, A. W. — Racine
Anderson, G. R. — Neenah
Bachhuber, F. G. — Mayville
Baker, J. C. — Hawkins
Barr, A. H. — Pt. Washington
Barrock, J. J. — Milwaukee
Baumgart, C. H. — Milwaukee
Beck, J. G. — Sturgeon Bay
Belknap, E. L. — Milwaukee
Benton, J. L. — Appleton
Berg, W. R. — Gillett
Bernhart, E. L. — Milwaukee
Bickler, E. P. — Milwaukee
Blanchard, P. B. — Cedarburg
Boren, C. H. — Marinette
Brehm, H. G. — Racine
Brehm, P. A. — Madison
Brizard, J. L. — West Allis
Broderick, C. F. — Milwaukee
Buckley, W. E. — Racine
Burbach, T. H. — Milwaukee
Burdon, T. S. — Green Bay
Burger, H. E. — Beloit
Brzezinski, E. A. — Milwaukee
Cantwell, R. C. — Shawano
Carey, E. J. — Milwaukee
Carhart, G. A. — Milwaukee
Carlson, G. W. — Appleton
Carson, W. J. — Milwaukee
Cary, E. C. — Reedsville
Caswell, H. O. — Ft. Atkinson
Christensen, F. C. — Racine
Christensen, H. H. — Wausau
Cleary, J. H. — Kenosha
Cleveland, David — Milwaukee
Collopy, P. J. — Milwaukee
Conroy, C. F. — Milwaukee
Constantine, C. E. — Racine
Costello, W. H. — Beaver Dam
Couch, T. T. — West Allis
Cox, J. A. — Milwaukee
Crosley, G. E. — Milton
Danforth, H. C. — Janesville
Demeter, N. D. — Milwaukee
Devine, H. A. — Fond du Lac
Dieterle, J. O. — Milwaukee
Donlin, William — Belleville
Dorchester, D. E. — Sturgeon Bay
Dundon, J. R. — Milwaukee
Dunst, C. G. — Milwaukee
Eberbach, C. W. — Milwaukee
Eck, G. E. — Lake Mills
Egloff, L. W. — Pewaukee
Eisenberg, P. J. — Milwaukee
Elliott, E. S. — Fox Lake
Erdmann, N. C. — Manitowoc
Fabric, B. L. — Milwaukee
Farrell, H. J. — Milwaukee
Fazen, L. E., Jr. — Racine
Fernan-Nunez, M. — Milwaukee
Fidler, Charles — Milwaukee
Fitzgerald, R. E. — Milwaukee
Foerster, H. R. — Milwaukee
Ford, W. B. — Milwaukee
Frederick, R. H. — West Allis
Friske, O. W. — Beloit
Gallagher, J. T. F. — Madison
Ganser, W. J. — Madison
Gates, J. F. — Wauwatosa
Gavin, S. E. — Fond du Lac
Gillett, G. N. — Racine
Goldberg, Nat — Milwaukee
Greene, H. L. — Madison
Grill, John — Milwaukee
Grossmann, L. L. — Milwaukee
Grove, W. E. — Milwaukee
Grover, F. L. — Hartland
Gruenwald, Ludwig — Sheboygan
Guerin, L. H. — Milwaukee
Gundersen, Gunnar — La Crosse
Gunderson, R. H. — Beloit
Gunther, T. J. — Sheboygan
Habbe, J. E. — Milwaukee
Hansen, H. J. — Sheboygan Falls
Hansen, J. W. — Milwaukee
Hanson, O. H. — Ft. Atkinson
Hebenstreit, A. J. — Waupun
Hegner, G. T. — Appleton
Heidner, F. C. — Milwaukee
Heifetz, E. C. — Milwaukee
Hemmingsen, T. C. — Racine
Heraty, J. A. — Milwaukee
Hermann, W. C. — West Allis
Hildebrand, W. B. — Menasha
Hipke, L. W. — Milwaukee
Hirsh, L. H. — West Allis
Hoffmann, G. H. — West Allis
Hougen, E. T. — Sheboygan
Hudson, E. D. — Lake Geneva
Hunter, Amy Louise — Madison
Irvine, R. K. — Manawa
Irwin, Robert — Milwaukee
Jensen, F. G. — Menasha
Johnson, J. M. — Ripon
Jones, M. L. — Wausau
Jorgenson, H. L. — Marinette
Joseph, W. A. — Milwaukee
Kalb, C. H. — Grafton
Karsten, J. H. — Horicon
Kay, E. M. — Milwaukee
Kenney, H. J. — Delavan
King, J. M. — Milwaukee
Kline, C. L. — Racine
Knauf, A. J. — Sheboygan
Kozina, F. J. — Milwaukee
Kreul, R. W. — Racine
Kriz, G. A. — Milwaukee
Kurten, R. M. — Racine
Kustermann, A. F. — Milwaukee
Lando, D. H. — Waukesha
Lee, P. A. — Milwaukee
Lifschutz, L. M. — Racine
Lindner, A. M. — Racine
Lokvan, L. H. — Kenosha
Long, C. W. — Milwaukee
Ludden, J. B. — Milwaukee
Lungmus, B. A. — Milwaukee
MacDonald, W. H. — Lake Geneva
MacGregor, J. W. — Portage
MacLaren, J. B. — Appleton
McCarey, A. J. — Green Bay
McGary, Lester — Madison
Maas, W. C. — Rio
Marshall, V. F. — Appleton
Mason, E. W. — Milwaukee
Mason, R. W. — Marshfield
Mayfield, A. L. — Kenosha
Megna, Salvatore — Milwaukee
Metcalf, G. S. — Janesville
Mielke, E. F. — Appleton
Miller, E. W. — Colgate
Miller, H. C. — Racine
Minahan, P. R. — Green Bay
Mitchell, S. R. — Milwaukee
Montgomery, R. P. — Milwaukee
Morgan, J. E. — Milwaukee
Morrison, M. T. — South Wayne
Munn, W. A. — Janesville
Murphy, F. D. — Milwaukee
Nammacher, T. H. — Oconomowoc
Nee, Frank — Spring Green
Nereim, T. J. — Madison
Niland, P. J. — Milwaukee
Oakland, H. G. — Milwaukee
Oberbreckling, P. E. — Milwaukee
Oberfeld, H. H. — Milwaukee
O'Brien, E. J. — Green Bay
O'Brien, P. T. — Menasha
Olson, L. C. J. — Delafield

Ozonoff, J. B.—Milwaukee
Park, C. F.—Milwaukee
Pessin, S. B.—Madison
Peters, L. M.—Milwaukee
Peterson, R. O.—Racine
Pfeifer, E. C.—Racine
Pifer, P. E.—Kenosha
Pomainville, H. G.—Nekoosa
Popp, Albert—Milwaukee
Purtell, R. F.—Milwaukee
Quade, R. H.—Neenah
Quick, E. W.—Milwaukee
Quigley, L. D.—Green Bay
Radloff, A. C.—Plymouth
Rector, A. E.—Appleton
Rees, T. H.—Manitowoc
Regan, J. R.—Milwaukee
Reinke, C. C.—Milwaukee
Reuter, M. J.—Milwaukee
Reznichek, C. G.—Madison
Rice, E. M.—Milwaukee
Romberg, H. A.—Oshkosh
Rosenheimer, A. M.—Beaver Dam
Ruffolo, A. F.—Kenosha
Sander, O. A.—Milwaukee
Sargeant, H. W.—Wauwatosa
Savage, G. T.—Milwaukee
Schaefer, A. A.—Milwaukee
Scheele, F. M.—Waukesha
Schelble, E. J.—Milwaukee
Schlomovitz, E. H.—Milwaukee
Schmidt, E. R.—Madison
Schneider, C. C.—Milwaukee
Schneller, E. J.—Racine
Schulte, G. C.—Kenosha
Schumm, H. C.—Milwaukee
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Senn, U.—Milwaukee
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Tucker, I. N.—Racine
Tufts, Millard—Milwaukee
Twohig, J. E.—Fond du Lac
Van Hecke, L. J.—Milwaukee
Van Kirk, F. W.—Janesville
Wagner, R. F.—Oshkosh
Waldkirch, R. M.—De Pere
Walters, D. N.—Fond du Lac
Walton, W. B.—Milwaukee
Warschauer, B.—Milwaukee
Wegmann, N. J.—Milwaukee
Weisfeldt, L. A.—Milwaukee
Welsch, J. M.—Beaver Dam
Wendt, F. A.—Johnson Creek
Wetzler, S. H.—Milwaukee
Wheeler, R. M.—Madison
Wier, F. A.—Racine
Wiesender, A. J.—Berlin
Wild, J. P.—Milwaukee
Wilkinson, J. D.—Oconomowoc
Winnemann, W. J.—Milwaukee
Wirig, M. H.—Madison
Wolcott, W. E.—Green Bay
Wolter, S. H.—Milwaukee
Wright, H. H.—Milwaukee
Wright, R. S.—Racine
Yockey, J. C.—Fond du Lac
Zivnuska, J. F.—Milwaukee
Zlatnik, A. P.—Two Rivers

Industrialists

Alexander, John D.—American Brass Co.—Kenosha
Anderson, Mr.—Oil Gear—Milwaukee
Armour, Morton—Rapco Leather Co.
Barelman, H. G.—Employers Mutuals—Milwaukee
Bartell, L. L.—Maynard Electric Steel Casting Co.—Milwaukee
Beach, C. A.—Federal Sanitation Co.—Shorewood
Beck, Ernie—Holms Mfg. Co.—Kenosha
Beddard, E.—Allis-Chalmers Mfg. Co.—Milwaukee
Bloomquist, J. A.—Employers Mutuals—Milwaukee
Burczyk, H. J.—Industrial Commission
Burgardt, Mr.—Stolper Steel—Milwaukee
Christensen, C. A.—Hardware Mutual Cas. Co.—Milwaukee
Clemens, C. E.—Standard Accident & Ins. Co.—Milwaukee
Court, A. T.—General Motors Corp.—Detroit
Cukr, C. M.—New Amsterdam Cas. Co.—Milwaukee
Cyr, P. W.—London & Lancashire Ind. Co.—Madison
Dickof, H. D.—Hardware Mutuals—Milwaukee
Dinsmore, C. H.—Wis. Council of Safety
Dundore, M. W.—Beloit Iron Works—Beloit
Eisenbach, L. A.—Kimberly Clark Corp.—Neenah
Elsner, J. E.—Horlick's Malted Milk Corp.—Racine
Erickson, V. H.—Snap-On Tools Corp.—Kenosha
Flynn, W. J.—Slocum Straw Works—Milwaukee
Fraley, William—Burlington Mills, Inc.—Burlington
Gigl, A. H.—Oil Gear—Milwaukee
Gillard, L. C.—James Mfg. Co.—Fort Atkinson
Goes, F. T.—Victor Mfg. Co.—Milwaukee
Grede, A. L.—Grede Foundry, Inc.—Milwaukee
Greilach, Carl—U. S. Fertilizer—Milwaukee
Guild, G. C.—Ray-O-Vac Co.—Madison
Higgins, E. L.—Grede Foundry, Inc.—Milwaukee
Hirschboeck, N. W.—Luick Ice Cream Co.—Milwaukee
Holand, Harold—Wisconsin Anti-T. B. Assoc.
Huntley, E. W.—Horlick's Malted Milk Corp.—Racine
Idleman, H. A.—Liberty Mutual Ins. Co.—Chicago
Jaehning, H. T.—Hardware Mutuals—Stevens Point
James, A. D.—James Mfg. Co.—Fort Atkinson
James, W. D.—James Mfg. Co.—Fort Atkinson
Jensen, Clarence—Midwest Tanning Co.—Milwaukee
Jensen, Mr. & Mrs. Harold—H. C. Jensen Mfg. Co., Inc.—Racine
Johnson, H. C.—Northern Paper Mills—Green Bay
Johnson, J. T.—Employers Mutuals—Milwaukee
Kessler, Mr.—Stolper Steel—Milwaukee
Kieber, E.—Lakeside Bridge & Steel Co.—Milwaukee
Kilbourne, B. C.—International Harvester Co.—Chicago
Klemm, H. A.—Industrial Commission—Madison
Klumb, A. H.—West Bend Equipment Corp.—West Bend
Klumb, C. E.—West Bend Equipment Corp.—West Bend
Kroening, C. W.—Employers Mutuals—Wausau
Krogson, Mr.—Ampco Metal—Milwaukee
Kuechle, B. E.—Employers Mutuals—Wausau
Kull, G. F.—Wisconsin Manufacturers Assoc.—Madison
Lange, Fred.—Crucible Steel Casting Co.—Milwaukee
Langworthy, E. E.—The Travelers Ins. Co.—Milwaukee
Larson, Mr.—Schlitz Brewing Co.—Milwaukee
Lee, M. T.—Lumbermens Mutual Cas. Co.—Milwaukee
Livesay, H. L.—Western Metal Specialty Co.—Milwaukee
Lloyd, M. J.—Horlick's Malted Milk Corp.—Racine
McClasky, B. J.—Hoberg Paper Mills—Green Bay
McCormick, J. A.—Ampco Metal
McQueen, R. L.—Hartford Acc. & Ind. Co.—Racine
Meiter, E. G.—Employers Mutuals—Milwaukee
Meyer, P. C.—Universal Foundry Co.—Oshkosh
Meyer, W. E.—Plankinton Packing Co.—Milwaukee

Mielenz, A. E.—Aetna Life Ins. Co.—Milwaukee
Moore, Will—James Mfg. Co.—Fort Atkinson
Murphy, L. E.—Murphy Products Co.—Burlington
Nagel, J. S.—Zurich Insurance Cos.—Chicago
Nelson, H. A.—Industrial Commission—Madison
Netzow, Charles—Ampco Metal, Inc.—Milwaukee
O'Day, John—Wisconsin Telephone Co.—Milwaukee
Oelschlaeger, W. J., Jr.—Ed. Schuster & Co., Inc.—Milwaukee
Oldenburg, H. F.—Oscar Mayer & Co.—Madison
Olson, M. G.—Hartford Acc. & Ind. Co.—Racine
Patzke, R. A. — Milwaukee Electric Tool Corp. — Milwaukee
Peirce, A. R. — Employers Assoc. of Milwaukee — Milwaukee
Pettis, Walter — Wisconsin Bridge & Iron Co. — Milwaukee
Pihl, H. O.—Louis Allis Co.—Milwaukee
Plotkin, Oscar—Midwest Tanning Co.—Milwaukee
Post, A. H.—Harley-Davidson Motor Co.—Milwaukee
Ranistack, Robert—U. S. Glue Co.—Milwaukee
Ricketts, T. H.—Scanlan-Morris Co.—Madison
Roberts, Mr.—Ampco Metal—Milwaukee
Rodeman, Paul — Wisconsin Bridge & Iron Co. — Milwaukee
Runkel, Laverne—Scanlan-Morris Co.—Madison
Ryan, Phil—Cutler-Hammer, Inc.—Milwaukee
Scates, W. H.—Camaten Co.
Schlotthauer, G. M.—Bituminous Casualty Co.—Madison
Schlueter, C. F.—Employers Mutuals—Wausau
Schwahn, Mr.—Badger Malleable Co.
Shearer, Conrad—Kenosha Mfrs. Assoc.—Kenosha
Sheets, Ralph—Koehring Co.—Milwaukee
Shoman, H. W.—Northern Paper Mills—Green Bay
Siebert, R. L. — Milwaukee Electric Tool Corp. — Milwaukee
Sladky, Mr.—Stolper Steel—Milwaukee
Smart, Mr.—Stoker Unit—Milwaukee
Sterling, E. D.—Yawkey-Bissell Co.—White Lake
Sweitzer, J. M.—Employers Mutuals—Wausau
Tillotson, Mr.—Stoker Unit—Milwaukee
Town, F. E. — Medusa Portland Cement Co. — Manitowoc
VanCleaf, W. C. — Allis-Chalmers Mfg. Co. — Milwaukee
Verden, Ted—Northwestern Barrel Co.
Verfurth, John — Lindemann & Haverson Co. — Milwaukee
Watson, R. S.—Employers Mutuals—Milwaukee
Weber, A. G.—National Tea Co.—Milwaukee
Weisleder, W. A. — Liberty Mutual Ins. Co. — Milwaukee
Wortmann, A. L.—Aetna Casualty & Surety Co.—Milwaukee
Zabler, Earl—Crucible Steel Casting Co.—Milwaukee
Ziegler, E. E.—Employers Mutuals—Milwaukee

Guest Physicians

Baird, H. D.—Montreal
Driessel, R. H.—West Bend
Gilbert, N. C.—Chicago
Hansen, T. L.—Chicago
Hudson, L. A.—King
Klepser, R. G.—Washington, D. C.
Knox, L. M.—Milwaukee
Kurten, L. J.—Milwaukee
Lindert, M. C.—Milwaukee
McNealy, R. W.—Chicago
Merewether, E. R. A.—England
Shannan, C. E.—Chicago

Nurses

Bast, Mrs. E.—Milwaukee Saddlery Co.—Wauwatosa
Blaney, Mary—Hoberg Paper Mills—Green Bay
Boemer, L.—Jacobsen Mfg. Co.—Racine
Brewer, Marion—Wisconsin Anti-T. B. Assoc.—Milwaukee
Brown, Phoebe—Employers Mutuals—Milwaukee
Buck, M. E.—Ampco Metal, Inc.—Milwaukee
Burgess, Pearl—Northern Paper Mills—Green Bay
Dennison, R. M.—Milwaukee
Glienke, Ruth—Ampco Metal, Inc.—Milwaukee
Golden, Cora—Employers Mutuals—Appleton
Hanson, Eleanor—Twin Disc Clutch Co.—Racine
Herman, Miss—Stolper Steel—Milwaukee
Hoffmann, Jeanette—Wausau
Kereim, Doris—W. A. T. A.—Milwaukee
Knutson, Helen—Perfex Corp.—Milwaukee
Koetting, M. C.—Milwaukee
Kuehnert, Lucy—Employers Mutuals—Milwaukee
Ladl, A. E.—Milwaukee
Leitgeb, Miss—Stoker Unit—Milwaukee
Lewis, Mrs. B.—Hansen Glove Corp.—Milwaukee
Makys, Annie—Walker Mfg. Co.—Racine
Miller, Irene—Visiting Nursing Assoc.—Milwaukee
Mory, Rose—Combined Locks Paper Co.—Combined Locks, Wis.
Nelson, Leona—Federal Malleable Co.—West Allis
Nugent, Mary—Twin Disc Clutch Co.—Racine
Porter, R.—Chain Belt Co.—Milwaukee
Ranum, Miss—Ampco Metal—Milwaukee
Reinkoher, Bernadine—Glove Union—Milwaukee
Schoofs, A. B. — Greenbaum Tanning Co.—Milwaukee
Seifert, Jane—Western Metal—Milwaukee
Silbaugh, F. E.—Oscar Mayer Co.—Madison
Stone, Miss—Kempsmith Machine—Milwaukee

Miscellaneous

Belknap, Elston, Jr.—Milwaukee
Blunk, Ella—Globe Union
Brewer, B. J.—Wauwatosa
Dunn, Clarence
Fluck, W. Z.—Wisconsin Board of Health—Madison
Haydon, G. F.—Milwaukee
Henry, R. B.—Wauwatosa
Hull, T. G.—American Medical Association
Lawe, Chester—Milwaukee
Levitan, Mortimer—Attorney General's Office—Madison
Merton, Mr.—City Attorney's Office—Milwaukee
Muth, C. J.—Milwaukee Assoc. of Commerce
O'Donovan, Edward—Milwaukee County Hospital
Olson, Cedric
O'Meara, M. T.—Milwaukee County Hospital
Oyen, Henry—Milwaukee
Roder, O. T.
Schartow, F. E.—Racine
Service, B. C.
Shauer, Lea—Milwaukee
Speers, Harold
Voight, Ray
Wanamaker, C. L.
Wanvig, J. D., Jr.
Worshauer, Arthur
Zeit, Walter—Marquette Medical School

Medical Students—Marquette

Arneth, J. J.
Audino, Herman
Bernstein, Syrene
Biasini, B. A.
Bigford, Walter
Bilecky, William
Bliwas, Arnold
Burton, J. W.
Buser, J. W.
Bush, Fred
Carlson, D. J.
Dargay, C. P.
Demy, George
Detesco. A. A.
Fisichella, R. A.
Fox, R. E.
Gericke, J. T., Jr.
Giaccone, J. S.
Hall, W. E.
Jauquet, J. M.
Kane, John
Klaas, Frederick
Knoedler, William
LaBiaseomase, Paul
Lapham, L. M.
LaSusa, T. J.
Luckemy, Cal
Lukes, R. E.
Matt, J. R.
McLean, Howard
McMurray, Lucy
Nelson, G. E.
Pulcero, Michael
Rehal, J. R.
Robinson, H. H.
Roncke, George
Schmidt, R. T.
Stemper, John
Strutz, William
Tonnaus, Thomas
Veit, Henry
Waldkirch, Bernard
Yamczak, James

Transactions, 1942 Sessions, House of Delegates, State Medical Society of Wisconsin

SUNDAY SESSION

The first session of the House of Delegates was called to order by Speaker R. M. Kurten, Racine, in the Banquet Room of the Hotel Schroeder, Milwaukee, at 5:00 p. m., Sunday, September 13, 1942.

Dr. C. A. Armstrong, Prairie du Chien, presented the report of the Committee on Credentials, showing registration of forty-four members of the House and thirteen councilors, which upon motion of Dr. E. C. Cary, Reedsville, variously seconded, was accepted as the roll of the session.

It was suggested as a recommendation of the Council that all sessions of the House be held as executive sessions to permit freedom of expression, and there being no objection, upon motion of Dr. L. O. Simenstad, Osceola, seconded by Dr. C. A. Armstrong, Prairie du Chien, such status was ordered until adjournment sine die on Tuesday, September 15.

At this point in the proceedings, the speaker of the House addressed the delegates, members of the Society and guests present relative to the problems of the House and those of medical statesmanship during this period of national emergency. In his address to the House, Dr. Kurten encouraged germane discussion by all members present during the deliberations. Declaring that there were many aspects of medical practice to be considered by the delegates, as "statesmen of medicine," Dr. Kurten said, "When we last met war was imminent. Today, it is a painful actuality, and we find ourselves engaged in a war with efficient, wily, unethical and powerful adversaries. The leaders of the Axis countries are absolute rulers militarily, economically and politically. We, on the other hand, are still adhering to democratic standards, albeit they are somewhat encroached upon. We are finding our enemies diabolically resourceful and well supplied with tools of war, and they are dangerously close to territories whose resources are rich in oil, minerals and fertile acreage for replenishing them. Only a total effort will stay the tide of defeat. There is no further place for the optimistic visionaries of the pre-Pearl Harbor period. The American way of life must go by the board temporarily and our economy be scaled to the exigencies of war.

"All this is of vital concern to us charged on the state level with the responsibilities of medical practice, economics and sociology. In the first place, are we going to supply personnel through our own agencies for the armed forces?

"Second, will those remaining on the home front be able to render adequate and efficient service on the present basis of private practice?

"Third, what is already in the minds of our national planners regarding the distribution of medical care?

"Fourth, what is going to be the attitude of our professional brethren—some forty to fifty thousand of them—returning four or five years hence from war, towards our present form of practice and our organization?

"These and many other aspects of medical practice are for us to ponder as statesmen of medicine. We must attempt to guide it into healthy, robust and honorable form so that those principles and institutions which make American medicine the highest in the world may be preserved for posterity."

After outlining various activities of the Society and particular problems confronting medicine, and the impact of the national emergency on them, Dr. Kurten emphasized the concern that must be held by all medical men with respect to the public health problems of the day.

Appointment of Reference Committees

The Speaker then announced the appointment of the following reference committees of the House:

Committee on Credentials: Dr. C. A. Armstrong, Prairie du Chien, chairman; Dr. O. A. Stiennon, Green Bay; Dr. W. M. Trowbridge, Viroqua.

Committee on Reports of Officers and Standing Committees: Dr. Irwin Schulz, Milwaukee, chairman; Dr. A. M. Christofferson, Waupaca; Dr. T. C. Hemmingsen, Racine; Dr. J. E. Trumbo, Wausau.

Committee on Resolutions and Amendments to Constitution and By-Laws: Dr. K. H. Doege, Marshfield, chairman; Dr. L. O. Simenstad, Osceola; Dr. Charles Fidler, Milwaukee; Dr. J. S. Supernaw, Madison; Dr. H. M. Caldwell, Columbus.

Following approval of the minutes of the 1941 sessions of the House of Delegates as printed in *The Wisconsin Medical Journal* for December, 1941, the speaker presented officers of the Minnesota State Medical Association including Dr. H. E. Giffin, president; Dr. W. L. Burnap, chairman of the Council; Mr. Manley Brist, legal counsel; and Mr. R. R. Rosell, executive secretary. Dr. C. N. Neupert, assistant state health officer for Wisconsin, was introduced to the delegates. Doctors Giffin and Burnap spoke to the House.

Supplementary Reports

Reports of officers and standing committees, supplementary to those published in the September, 1942, issue of *The Wisconsin Medical Journal,* were then given.

Dr. S. E. Gavin, Fond du Lac, as chairman of the Council, presented an amendment recommended by the Council to permit the affiliation of physicians as

members at per capita reduced dues where licensed to practice medicine and surgery in Wisconsin and holding positions as hospital residents or research fellows. Following the report of Dr. Gavin, the speaker then called upon the president of the Society, Dr. Gunnar Gundersen, La Crosse, who then addressed the House with respect to his year in office.

Address of President Gundersen

Mr. Speaker, Members of the House, and Guests: I am very happy to see our friends from Minnesota here today. The method under which we are functioning at this meeting, namely, starting our meeting on Sunday, is really a Minnesota innovation, and I hope you will like it so well it will become a permanent feature of our meetings. I feel, as one who has been a member of this House for many years, that under our old system we spent so much time with the business activities of the House it left very little time to attend the scientific sessions, and I think that this is probably one way of solving it. I even suggested to Charlie that we might have the Council meet Saturday evening, as they sometimes do in Minnesota, in order to give that body sufficient time to deliberate.

". . . the Stewardship of Your Officers . . ."

As your retiring President, it becomes my duty and happy privilege to give you an accounting of the activities of the State Society during the past year so that you have some idea relative to the stewardship of your officers.

Through the annual reports of the officers and committees, which have been in your hands for some weeks, it has been possible for you to develop in summary form a clear idea of the activities of the Society during the year just past.

Consequently, I do not intend to review in detail either the work of the Society or of each individual committee but rather to single out some of the work for comment and to re-emphasize points which to me seem to be of importance. Of the many committees of the Society, it is hazardous to single out any for special commendation for fear others equally worthy may be neglected.

Due to conditions beyond our control, which came about as the result of the death of our secretary in June of last year and the fact that his place was not filled until the annual meeting of the Council in January, the normal activities of the Society did not gain momentum until our new secretary was sufficiently oriented in the maze of work so that he could take an active part in the direction of the manifold duties which became his. Added to this was our entry into the war in December, which fact alone threw an additional burden onto the Society. In the opinion of the Council and your officers, the entry of the United States into the World War became of primary importance and all other activities of the Society assumed secondary importance to that of aiding in the prosecution of the war effort.

The use of the Society office by Procurement and Assignment might well have taken the time and effort of the entire personnel, and it is to the great credit of our secretary and the personnel of the office that they were able to assume the added burdens of Procurement and Assignment without appreciably increasing the personnel nor making an additional impact on our already strained budget.

". . . a Highly Commendable Job . . ."

It should hardly be necessary for me at this time to add anything relative to the work already done by the Procurement and Assignment Service. This agency, navigating in an uncharted sea, has done a highly commendable job. However, occasional errors were bound to occur. Mistakes of the mind there may have been, and undoubtedly have been, but they have not been of the heart for no activity of our Society has ever been entered upon with greater open-mindedness and with greater desire to do a job well.

Just on the side, I should like to pay my particular compliments and respects to Dr. Bob Fitzgerald for the herculean job he has done during these past months. I think he deserves it.

As far as the organized profession of medicine in Wisconsin is concerned, when the history of this war is written one of the brightest pages will be that one concerned with the contribution of Wisconsin physicians *in* service and *out* of service. I have deliberately added those "out of service" for in total war it is quite as important to maintain health and well-being on the home front as on the battle front.

". . . sufficient Wherewithal . . ."

It is possible now after nine months to evaluate fairly accurately what the load in the immediate future may be, but no one can foretell with accuracy what the load might become in 1943. For this reason it is the considered judgment of your retiring president that you supply the incoming officers with sufficient wherewithal in the form of dues in order that there may be no strictures placed upon the activities of the Society in a year which may prove to be one of the most important, if not the most important, in its history.

The *budget* is a problem with which the Council must wrestle subject to the limitations imposed by reason of the dues which are levied and which are fixed by this House of Delegates.

In 1935, upon the suggestion of the outgoing president, the late Ralph M. Carter of Green Bay, $500 was allocated to the president during his year in office to pay at least in part for travel, telephone, and other expenses incidental to his office. Your president at times has expressed criticism in regard to this expenditure. He is now in a position to speak from personal experience relative to expenses of this office. As an example, an accurate tabulation of miles traveled during the two-year period (one year as president-elect and the second year as president) shows that over 23,000 miles have been cov-

ered, all necessary and incidental to this office. It is clearly evident the allotment is insufficient even for travel.

Fortunately the men who have occupied this office, in my memory, have not required grants in aid and have personally been able to bear the additional expense incidental to the office. My recommendation now is to continue this appropriation at the present level and to increase it in the event some worthy president, but one probably not so well situated financially, should occupy the office; or, better still, perhaps compensate him for actual expenses incurred during his tenure of office.

The Committee on Health and Public Instruction this year has embarked upon a new venture—public health education in our County Fair exhibits. It is an interesting development which, I believe, bears watching and one which undoubtedly has large possibilities in the general field of public instruction in which we all should be interested.

I have it directly from the State Commander of the Women's Field Army, Mrs. G. E. Stoddart, that there has been great progress during the last year; furthermore, the Field Army program has continued to function despite the war emergency, and every county leader is reporting encouragement insofar as it is continually becoming easier to create interest in the activities of this crusading organization. There have been a greater demand for exhibits, a heavier schedule for the showing of films, and the supply of literature has been exhausted though an ample supply was thought to be on hand.

The success of the Women's Field Army is in no small measure due to the work of the Society's Committee on Cancer and to the efforts of its Chairman, Dr. Charles Fidler, who, by virtue of his position, is also State Chairman of the Women's Field Army. To the Committee on Cancer, I wish to express the deep appreciation of the Society for tying up the medical profession of the State to an organization which is of inestimable importance in lay education in a field where enlightenment promises so much.

The Committee on Safety on Public Highways has submitted a report which should go a long way to clarify the problems with which it has been concerned. If legislation eventuates as a result of this effort, I believe the State Medical Society will be able to look with pardonable pride on the leadership the Society has taken in this lifesaving activity even though strictly speaking it does not belong to the field of medicine as such.

To the committee charged with the study of problems relating to the Medical Practice Act goes credit for doing the "spade work" which is necessary for the enactment of a law in the State of Wisconsin which is long past due. If this committee is continued by the House of Delegates, which I hope it will be, until the present archaic Medical Practice Act is revised, the State Society should receive credit for promoting a public health measure for which generations to come will be grateful.

Committee on Public Policy—During the year an emergency arose relative to an endorsement given to butter substitutes by the Council on Foods of the American Medical Association. This endorsement was in direct conflict with the dairy interests of the State of Wisconsin. I am of the opinion there was considerable justification for the resentment manifested by men representing the dairy interests of Wisconsin over this endorsement.

". . . endorsing Dairy Butter . . ."

Fundamentally there is not and should not be any conflict between the scientific farmer and dairyman of the State of Wisconsin and the men of medical science. Competent authority is agreed that there is an unknown factor present in dairy butter which is lacking in butter substitutes. For this reason, I feel this House may well go on record in no unequivocal terms endorsing dairy butter in preference to substitutes. Until science has proved otherwise, the physician of Wisconsin will remain loyal to his best friend, the scientific dairy farmer, who in less than two generations has transformed a ramshackle agricultural state to the premier dairy state in the Union.

Interestingly enough conditions over which our Society, and particularly its officers, had no control have brought about changes which in all seriousness had been recommended by your incoming presidents-elect during the past two years.

Firstly, with tire rationing there has been in many areas of the country an associated lowering of the speed limits to a level or ceiling, which may well be considered within safe limits, resulting in a decreased number of deaths on highways. It may well be the difference in the number of serious accidents before and after the forty mile per hour limit may prove to be so startling, an enlightened and enraged public opinion will demand slower speeds when the war emergency has passed.

Secondly, daylight saving, which was recommended here two years ago and which was rejected by the Wisconsin legislature, may prove to be of such great value, both economically and to the health of the people, we shall reluctantly give it up when the war emergency is over. Perhaps even rural Wisconsin, which was wholeheartedly against changing time, shall have undergone a change of heart.

". . . mountain of Labor . . ."

In this brief review, many committees and their work have not been mentioned by name. This does not imply they or their work are of secondary importance; far from it, for it is often the obscure work done quietly without fanfare which is of greatest value and which in the general run of Society activities is of greatest importance. The daily work of your officers is of this type, and only those who have had the privilege of serving in a position close to headquarters have any clear idea of the mountain of labor which is turned out daily by your Society.

To all those, both on the inside and the outside, who have done their utmost to make our Society great, I say my humble "Thanks."

At the conclusion of the report of Dr. Gundersen, the speaker then called upon President-Elect F. E. Butler of Menomonie.

Address of President-Elect Butler

Mr. Speaker and Members: I am going to surprise you by not lauding Minnesota, just for a change.

It is with a profound sense of pride and a deep sense of humility that I accept the responsibilities placed upon me as the incoming president of the State Medical Society of Wisconsin. In the critical years during which we have been bound together as a medical profession—bound together by that unanimity of purpose to bring to the people of our state and, through our organization, to the people of the entire country, the best and most adequate care available in the world today—one is made humble by the fear of his own incapacity to continue the brilliant leadership that has preceded him.

Our profession, from its founding, has been accustomed to, but never reconciled to face, those facts which are most fundamental in man's relationship to the great unknown,—the facts of birth and death. Now we share a kinship with all citizens of the United States as well as those of the entire world, for at no other time, in any period of history that has preceded, have the people of all countries so clearly faced destiny.

I am comforted in the thought that, as president of the State Medical Society of Wisconsin, I am simply treading along the way of those who have marked the path for the profession of medicine.

It would ill befit me, therefore, to sound a clarion call to a group that has been so persistently aware of what has been going on before. Rather, it seems better that I talk with you very informally about a few general matters which have deeply interested me as a member of the Society, and upon my interest in the future of that organization, to offer certain specific recommendations. As an introduction, I think you and I should review the organization of the State Medical Society of Wisconsin,—the kind of organization it is, the need that exists on the part of us as individual physicians to support it, and the good that comes from it, in science, in public health achievements and advancements, in unity and in friendship.

". . . a Grand Pooling of Ability . . ."

The most cursory reading of the Constitution and By-laws in the annual Blue Book edition of *The Wisconsin Medical Journal* enables any one of us to see the machinery of the Society. But to see it work, to see it function, to see it uphold the high ideals of a democratic organization, each one of us must appreciate that he, himself, is a part of that machinery. Each should exercise that privilege to bind his own personal aims and ideals to those of his colleagues, to those of his county medical society, to those of our State Society, to those of the American Medical Association and, finally, to those of humanity itself. In the many ways that are possible, the policy making organizations of our society carry to the individual members this thought, not alone as an obligation but as an opportunity, for the policies of medical groups such as ours do not develop from thin air,—they stem from the fertile thoughts of interested members, no matter how humble a position each may think he holds. The constant flow of suggestions, of constructive criticism, of willingness to participate and to understand, is fundamental to the continued success of an organization such as ours. In the years I have had the opportunity and the privilege of serving this Society and the profession of medicine as a delegate for six years, as a member of the Council, on various committees and during this last year as your president-elect, I am convinced that there is a grand pooling of ability and brainwork on the part of the physicians of Wisconsin.

". . . the Ideals for Which the Society Exists . . ."

But perhaps some of us fail to realize that through the standing committees, the special committees appointed by the incoming president each year, the various committees of the House of Delegates, the Council itself, and the subcommittees appointed by the Council, there is a large percentage of our membership being consulted constantly on the fundamental policies of the medical profession, men who without thought of personal reward are doing a splendid job for organized medicine in Wisconsin. The members of the committees meet on numerous occasions throughout the year, spending weekends away from home and fireside, sustained by the knowledge that they are acting with others to promote the ideals for which the Society exists.

Let us continue to support them as individual members and to convey to them not alone our appreciation but our constructive suggestions whenever the opportunity permits.

I said to you a few moments ago that, as part of a preliminary discussion, we should review the organization of the medical profession, and the thoughts which have preceded this portion of my discussion with you have been introductory to a review of still another phase of medical organization in Wisconsin.

". . . a Highly Specialized Staff . . ."

Of the hundreds of physicians practicing in this state, 2,600 of them are members of this Society. Through its executive office in Madison, it maintains a highly specialized staff, and I use that term advisedly for it is through a staff that is specially trained and highly competent that an effective organization may be produced,—an organization which may cope with the multitudinous problems that affect our profession as they are raised by the public and the government. Yet, in the development of this efficient and trained organization, I am happy

to state that in my judgment the concept that the State Medical Society is the society of each individual member has been continued from its early development by George Crownhart. I urge upon the members of the Society that when the opportunity presents itself, they stop in at the office in Madison to meet the staff, to view the office, to give their thoughts, reactions and suggestions, and to see as well as to hear how the State Medical Society of the State of Wisconsin functions as a potent organization in problems affecting the public health and the dissemination of scientific knowledge.

Let us, as official representatives of our own local medical groups, carry back to those organizations this thought and promote by that means the further development of a truly fine machinery.

". . . they Are Serving a Cause . . ."

Then, too, we must give thought to the problems existing for the medical profession and the public health in the future,—problems which demand the continuation of an organization developed through 100 years of effort. There is not a community in Wisconsin that has not had, or will not in the future have, its medical personnel affected by the present national emergency. To those of our profession who are privileged to serve in the armed forces, may I convey the thought humbly and sincerely that I envy them their opportunity to serve their country in this fashion. Yet, to those who remain at home that others may enter the armed forces, may I say that they are serving a cause equally fine and equally important. And to both of these groups may I say that those in service cannot do without those at home, and those at home cannot do without those in service.

When our minds and our hearts are dedicated so completely to the problem of ultimate victory, there is serious danger that our relative sense of values may "skip a cog" momentarily, with the possibility of seriously affecting the effective organization of our profession. At this point I would remind you of the necessity of continuing that basic support to our fundamental responsibility,—fundamental as it affects the public health, as it assists the profession to exchange, for the sake of humanity, the values of scientific medicine,—fundamental to the point that through organization we are each of us strong while individually our weakness might serve to defeat our value to the country. I would feel remiss if I did not note with a pride that I am sure each of you feels the outstanding activities of our Society in the publication of its monthly Journal, in the development of the postgraduate centers of education, in the splendid scientific program provided for this and other annual meetings, in the responsibility it accepts in the economic and social picture of today, in the promotion and maintenance of health education and health achievements, and in its cooperation with other groups whose interests are sound and selfless in the humanitarian spirit that must pervade the profession of medicine.

In bringing to a conclusion these introductory remarks, I should like to emphasize the need of the State Medical Society as one which exists to advance the usefulness of our profession through the promotion of unity and friendship within the profession.

". . . holds Out a Friendly Hand . . ."

Strife seems to be the very rule of life for the busy practitioner. He wages an incessant warfare against disease, ignorance and prejudice. He works from morning until morning, and in these days of national emergency the burdens which he must carry are many. But let us continue to develop the fellowship of medicine,—a fellowship defined as one in which the older practitioner holds out a friendly hand to the young practitioner, a fellowship defined as one in which the younger practitioner adheres to the Oath of Hippocrates and recognizes the State Medical Society as the professional cement that holds men of all ages, of all places, of all beliefs, to the one common purpose of the physician. I stress the need for continuing the meetings of the medical society in that friendly, informal atmosphere which develops and fosters open discussion of problems in a spirit that refuses to recognize any difficulty that is important enough to create either animosity or jealousy.

The meetings should be such as promote an habitually friendly mind, the old fashioned courtesy, the sympathetic understanding which makes it impossible for hardness of heart or envy or malice or hatred to crumble the foundations upon which the medical profession has stood impregnable for centuries.

With this introduction to my conception of the medical profession and the part which it plays in the national picture through the medical organizations, I now come to my specific recommendations.

". . . basic for the Future . . ."

First, I am convinced that the financial structure of our Society is sound, well balanced and without waste. I am convinced that the problems of the immediate future are so vast, so immeasurable and so difficult to forecast, that the present financial structure of the society must be maintained within the very limits of our ability to do so. It is the Committee on Resolutions of this House of Delegates which brings in its own resolution on the subject of annual dues. That its responsibility, and your responsibility, are complicated by the fact that many members of our society are now in service, and many more will be, under an arrangement which provides for complete remission of dues during the period of such service, is self admitted. That the income of the society will suffer, even if dues are maintained at their current level, seems unnecessary to state. But the planning of the society cannot be for a period of weeks or months; it must be in terms of years and even decades. It is my recommendation, therefore, that at this meeting of the

House of Delegates, under no circumstances should dues be decreased, but that the dues established now should be no less than they have been for this year and the year preceding, and that in the establishment of those dues it should be recognized that they are basic for the future, that the planning of the Society may develop from basic finances which may be augmented in the future from time to time, but shall never be lessened.

". . . on Leave of Absence . . ."

Second, it is my recommendation that the House of Delegates, by proper resolution, recognize the contribution made by those members who have entered, or who will enter, military or naval service of their country, and in recognizing this contribution, recognize further that entrance into service should not serve to defeat the leadership and the contribution which these men have given us in the years past or could give in the months to come. I have specific reference to the fact that in the committee structure of our society there are numerous individuals who are now unable to serve, and there are others who will be unable to serve in the future in an active sense, because of their participation in the war effort. It is, therefore, my recommendation that the House of Delegates continue such members in the service of the society on leave of absence, and that the president be authorized to appoint additional members to hold office during his presidency as war members of the various committees. Believing that this merits your serious consideration, becaues of the problems that now exist, I further ask the indulgence of the House to permit me to refrain from announcing committee appointments until the Tuesday morning session when this subject may have been acted upon, and upon which action I can definitely determine those appointments.

". . . is Sound and Realistic . . ."

Third, I invite your careful attention to the special report of the Committee on Voluntary Sickness Insurance, which was transmitted to you by the secretary's office during the week just past. It is my firm opinion that the report of that committee is sound and realistic, and to carry out its thoughts and to serve further the responsibilities of our Society, it is my recommendation that each county medical society appoint a committee of its members to study local problems in this field and to explore the possibility of meeting further local needs. I consider this problem one of the most important questions before the medical profession today,—the problem of developing further safe and sane methods of modern medical care. I grant that there has been a temporary improvement in various economic conditions, but this synthetic situation of war cannot be interpreted as having a permanent effect. There is no lull in the proposals of those from without the profession although there possibly may be a different method of approach. In other words, this is not a dead issue but, on the contrary, an exceedingly current issue. We should not be misled nor should we permit ourselves during this period of heavy responsibility to adopt a "do nothing" attitude. In my judgment, we must continue for the future the policy we have followed for the past, and the proposals of the Committee on Voluntary Sickness Insurance are worthy of your most serious consideration.

I call your attention also to the report of the Committee on Interprofessional Relations. I have noted with interest the experiment effected in Minnesota pertaining to the reviewing of expert testimony. In the colloquial language of today, I surmise that "Minnesota has something." During this coming year, it is my hope that the committee organizations of the State Medical Society will undertake a careful survey of that subject. I fully concur in the thought recommended by the two committees mentioned and suggest to you the possibilities therein contained.

Another matter occurs to me that seems worthy of your consideration. In my experience with the Society, I recognize the office of secretary of local county medical societies as a vital link in the chain of organization. Many of them have served long and faithful periods in giving friendly service, and, to an extent that could be only self imposed, effort and time to the advancement of medical organization.

". . . recognition of Their Efforts . . ."

Some years back it was the policy of the State Medical Society to hold an annual conference of county medical society secretaries and presidents. But the expense of these conferences forced their temporary discontinuance during the period when medical societies were faced with so many matters which demanded the utmost of their energies and strength. It occurs to me now that the secretaries' conference could be re-established by having the House of Delegates instruct the secretary's office of the State Medical Society to extend, on behalf of the House of Delegates, a cordial invitation to be present at all of its sessions, but particularly the first session. The secretaries could be called into meeting several hours in advance of the House of Delegates and, thus, as a part of the annual meeting of the State Medical Society, their interest could be served, the interests of the profession would be served, and recognition of their efforts and work in behalf of the Society could be extended by the House of Delegates.

". . . an Imperative Need . . ."

Last year this House acted upon the recommendation of President Gundersen and supported the resolution offered by Dr. R. G. Arveson, which created a special committee of the House to study problems relating to the Medical Practice Act. It is debatable, perhaps, as to whether this committee should be continued as a standing committee of the Society for perhaps its functions in the not too far

distant future might be transferred by the House of Delegates to one of the other standing committees and, thus, obviate the necessity for still another committee in the structure of our Society. But, in my judgment, an imperative need exists for the continuation of this special committee of the House during this forthcoming year and, possibly, for some time after that. I therefore recommend to the House that by resolution this committee be continued as a special committee of the House.

The Commander in Chief of our nation, in the first of his three war talks to our people, pointed to the civilian casualties which last year reached a staggering total of 3,500,000. In furthering our nation's war effort, he stressed our responsibility in industry and in safety on the public highways to prevent the loss or injury of those lives needed by our country in using every resource most effectively. President Roosevelt stated that automobile accidents during the last year killed 40,000 and injured 1,500,000 more, while industry accounted for fatal accidents to 19,200 and injuries to 2,000,000.

I note also the report of our Special Committee on Safety on Public Highways and the program outlined by the Committee on Industrial Health. I commend these for your serious consideration and seek the approval of this House to continue the Special Committee on Safety on Public Highways during the ensuing year.

". . . this Valuable Storehouse of Information . . ."

During his address to the House of Delegates in the Fall of 1941, Dr. Gundersen spoke of the subject of medical economics and told of his belief that the work of the Society over a period of years was of sufficient importance that the Committee on Medical Economics of the Society should be provided with the wherewithal and the assistance to continue the studies that during these past years involved so much of the Society's time, effort, finances and personnel. Dr. Gundersen said, "Our annual Blue Book is devoted, in large measure, to these questions, and I believe this addition to our *Journal* is of the greatest value to the men in the field, serving them as a reference book throughout the year. I am of the opinion that in the future, as a further service to the members, this valuable storehouse of information should also contain a group of subjects which would fall under the general heading of 'Distribution of Medical Services in Wisconsin.' "

I appreciate that during this last year the burdens thrust upon the medical profession, as a result of our nation entering war, have been many, varied and extensive. But it is also my belief that the recommendation of President Gundersen, approved in spirit by the House of Delegates in 1941, should be reaffirmed by this House of Delegates for the purpose of instructing, generally, our officers and councilors to carry forward this thought whenever and wherever feasible.

". . . no Action Which Would Jeopardize . . ."

Thus I conclude my specific recommendations, but I must add one further thought. From time to time in the past and perhaps, indeed, even at this session of the House of Delegates, we may hear suggestions that the organization of the State Medical Society can in some method or in some manner be "streamlined" for the purpose of creating greater effectiveness and avoiding waste of the energy and the strength of our secretarial office. I have entertained such thoughts myself but a moment's reflection convinces me that tradition should indicate that recommendations along this line should come from the outgoing president rather than from the incoming president. If, after my year of experience as president, it occurs to me that various methods may be devised to simplify the structure of our Society, it shall be my purpose to offer them to you at the time of my departure from office. But in the meantime, I feel convinced that nothing should be contained in my recommendations, and no action should be taken which would in any way jeopardize the strength of a medical society which is so outstanding in its accomplishments in behalf of public health and in behalf of the physician.

Now, in conclusion, may I say once again that I appreciate the honor that has been conferred upon me, and my responsibility can be no less than to discharge the functions of the office of president to the best of my ability and judgment, in a conscientious effort to continue the achievements of the State Medical Society of Wisconsin.

To our outgoing president, Dr. Gunnar Gundersen, I express, on behalf of all physicians of the state, a sincere message of appreciation for the untiring efforts he has given our Society during this last year. To the councilors and the other officers, and to the House of Delegates, may I say that I am impressed, beyond my power to voice, by your careful, conscientious and wholehearted efforts in the promotion of the cause of our Society. To each of you we owe a vote of thanks, which is woefully inadequate to express the sense of gratitude which is in the hearts of all of us. My thanks to you, gentlemen, for your indulgence and for your kindness, and I bespeak your co-operation in the months that lie ahead.

Other Supplementary Reports

At the conclusion of the address by Dr. Butler, the speaker put the question raised by Dr. Butler, that committee appointments be submitted at the third session of the House, and upon motion of Dr. Joseph F. Smith, Wausau, seconded by Dr. L. O. Simenstad, Osceola, the motion was carried.

Then followed a supplementary report by the secretary showing a total membership of 2,500 at the time of the first session, compared with 2,409 a year previous.

At this point in the proceedings, following report of the death of Dr. Christian H. Beyer, Milwaukee,

as supplementing those deaths reported in the September issue of *The Wisconsin Medical Journal*, and of the news reports that Dr. A. N. Tousignant, Oconto, and Dr. Charles Leasum, Sturgeon Bay, were missing in action, the House of Delegates rose in silent tribute to the physicians deceased since the 1941 session.

The speaker called for the report of the treasurer, Dr. Ira R. Sisk, Madison, which was as follows:

(For the period January 1 to August 31, 1942)

Cash on Deposit:	
Treasurer's account at the First National Bank of Madison	$41,554.38
Investment securies owned at par value	29,000.00
Proceeds of Insurance Policy on deposit with Aetna Life Insurance Company	8,788.00
Cash on Deposit:	
Secretary's Petty Cash account at the American Exchange Bank of Madison	300.00
Cash on Deposit:	
Secretary's Dues account at the American Exchange Bank of Madison	100.00
Total Funds	$79,742.38

Cash Receipts and Disbursements

Cash in Bank, January 1, 1942		$ 9,690.49
Receipts		
Membership Dues	$58,894.52	
Exhibit Space Rentals	2,332.50	
Interest on Investments	780.16	
Proceeds from the sale of Securities	7,226.30	
Graduate Center Fees	1,415.50	
Miscellaneous Receipts and Refunds	319.01	
Installments on Insurance Policy Proceeds	792.24	
Total Receipts		$71,760.23
		$81,450.72
Disbursements		
President's Travel	$ 500.00	
Council and Committees	2,017.31	
Books and Periodicals	218.19	
Delegates to A. M. A.	426.59	
Auxiliary	100.00	
Secretary's Salary	3,970.00	
Secretary's Travel Expense	1,113.73	
Salaries of Staff	7,666.63	
Assistant Secretary's Normal Travel	459.63	
Accounting and Insurance	278.68	
Social Security Taxes	290.55	
Rent	1,200.00	
Telephone and Telegraph	1,234.64	
Supplies and Light	644.47	
Postage and Printing	1,325.59	
Fixtures and Upkeep	206.53	
Miscellaneous	551.96	
Legal	567.56	
Special Bulletins to Members	33.42	
Annual Meeting	431.50	
Graduate Centers	1,506.25	
Wisconsin Medical Journal	1,400.00	
Industrial Health	3,630.72	
Disbursements—Continued		
Hygeia	$ 257.50	
Health and Public Instruction	815.64	
Lay Publications	28.50	
Services, general counsel	1,000.00	
Voluntary Sickness Insurance Trials	148.25	
Dues Refunded	778.25	
Exhibit Space Rentals Refunded	22.50	
Investment Securities Purchased	7,071.75	
Total Disbursements		$39,896.34
Cash in Bank, August 31, 1942		$41,554.38

Securities Owned

Description	*Interest Rate*	*Maturity*	*Face Value*
Pacific Telephone and Telegraph Company	3¼%	12– 1–66	$ 2,000.00
Milwaukee Gas Light Company	4½%	3– 1–67	3,000.00
Dayton Power and Light Company	3%	1– 1–70	3,000.00
Wisconsin Power and Light Company	3¼%	8– 1–71	3,000.00
Pennsylvania Power and Light Company	3½%	8– 1–69	2,000.00
Southern California Edison Co., Ltd.	3%	9– 1–65	2,000.00
Wisconsin Gas and Electric Company	3½%	4– 1–66	1,000.00
United States Treasury Bonds	3¼%	4–15–46	2,000.00
United States Treasury Bonds	2½%	9–15–72	3,000.00
United States Savings Bond—Defense, Series G, 1941	2½%	6– 1–53	2,000.00
United States War Savings Bonds	2½%	6– 1–54	6,000.00
Securities Owned, August 31, 1942			$29,000.00

Committee on Public Policy, Council on Scientific Work and Committee on Voluntary Sickness Insurance

". . . natural Dairy Butter . . ."

Dr. C. A. Dawson, River Falls, was called upon as chairman of the Committee on Public Policy, for a supplemental report, which included presentation of the following resolution:

"WHEREAS, During recent years there has arisen in the field of nutrition a group which has furthered the interests of butter substitutes, and

"WHEREAS, In the opinion of competent scientists in the field of nutrition there is a natural growth factor in unadulterated dairy butter which butter substitutes do not possess,

"*Therefore, be it resolved*, That the House of Delegates of the State Medical Society of Wisconsin go on record by giving its approval to natural dairy butter in preference to any artificial substitute."

Dr. George W. Krahn, Oconto Falls, chairman of the Council on Scientific Work, then discussed the year's work of his group in scientific articles, programs and activities, as well as postgraduate education. Also indicated were added activities which would fall within the purview of that committee, including industrial postgraduate work, geriatrics, and rehabilitation of service men after the war.

The speaker then called upon Dr. C. D. Neidhold of Appleton, chairman of the Committee on Voluntary Sickness Insurance, who asked careful consideration by the House of any recommendations of this committee and discussed the great amount of detailed work done by the committee during the past year.

Committee on Mental Hygiene and Institutional Care

Dr. H. H. Christofferson, Colby, next presented the report of his committee covering incidence of tuberculosis in state institutions, crowding of state hospitals with transfer to county hospitals indicated, and care of patients in the various county institutions.

Delegates to the American Medical Association

At this point, the speaker called for reports of the delegates to the American Medical Association, Dr. Joseph F. Smith, Wausau, Dr. S. E. Gavin, Fond du Lac, and Dr. James C. Sargent, Milwaukee, now in service with the U. S. Navy. Dr. Smith and Dr. Gavin reported on the 1942 annual session in Atlantic City, and the following telegram was read from Dr. Sargent, who was unable to attend this meeting of the State Society:

"Will you please convey to the House of Delegates my genuine regret over not being able to present in person my report as one of your A. M. A. delegates? I regret especially that I cannot be present with you during your deliberations in this particular session, for I am aware of some of the sizable problems that confront you. While our professional troubles seem dwarfed by the much greater matter of war, they are none the less real, and it is necessary that medicine not lose its identity or its cohesion in the shuffle. Best regards to all."

The Procurement and Assignment Service

Dr. R. E. Fitzgerald, Milwaukee, state consultant for the Procurement and Assignment Service, was called upon by the speaker for a report of the activities and accomplishments of the organization which he represents in Wisconsin. Dr. Fitzgerald's report follows:

With the executive order on October 30, 1941, which brought the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians into being, it was only natural to find the following months filled with incongruous statements and actions which led to confusion, embittered words and accusations which we all know are a part of a new order. Take a profession so individualistic in nature and suddenly demand a mass observation of rules and regulations so foreign to its nature, and you will find a certain amount of negative reaction to the new regime. Intolerance of interference of the government in our individual methods of approach, too, have resulted in misunderstanding, bitter accusations, and oftime actions not conducive to the solidarity so necessary for a victorious nation.

". . . to Judge the Availability or Essentiality of Each Doctor . . ."

But I am happy to inform you that I now believe that period is a closed chapter, and from now on response to our governmental needs are bound to be in keeping with the higher ideals of the profession. A committee in each councilor district was organized to supply information and data which would permit the Procurement and Assignment Service to judge the availability or essentiality of each doctor. This was a tremendous undertaking, and the results merit the approbation of the State Society. You must remember that Procurement and Assignment Service for Physicians has no power over the ultimate destiny of any one physician. We, as a service, cannot command a doctor to enter service. This is a voluntary affair on his part. All that Procurement and Assignment Service can do is to mark a man available or essential. Thereafter, it becomes the duty of the various governmental departments to take whatever steps they see fit in order to supply the medical needs of the armed forces.

Much has been said about the term "essential." What does the Manpower Commission mean by the term "essential," and when is a doctor considered essential? In the industrial field, all doctors are so classified who are necessary to the maintenance and supervision of an industry considered vital in the flow of its product to the armed forces and when the following conditions exist:

A. Full-time industrial physician

1. The physician is employed by an industry which is manufacturing war materials exclusively or under priority ratings, and
2. The physician gives his full time to the industry or forty or more hours weekly, has been so employed for at least two years or is especially trained for that purpose and is carrying on an acceptable health maintenance program, and
3. The physician is performing the functions of a medical director or department head or of a specialist or is the only physician employed.
4. Assistant physicians who perform routine functions under direction, and are employed on a full-time basis, are deemed essential until they can be replaced within a reasonable time (three to six months).

B. Part-time industrial physician.

1. The physician serves part-time two or more industries engaged exclusively in the manufacture of

war materials or under priority ratings, providing his total part-time service is the equivalent of forty or more hours weekly. Note: The physician who serves on call only is not deemed to be essential.

C. The physician serves a state industrial hygiene bureau on a full-time basis.

". . . medical Schools Must Not Be Sacrificed . . ."

Medical Schools. All physicians who are necessary for the speed-up curriculum in force, to the end that there shall be a sufficient number of physicians graduated each year to take care of the needs of the army, navy, industry and also community needs, are marked essential. I am of the belief that they merit your profound consideration because in the near future we will be confronted with a dearth of physicians so essential to the need of a complete and total war. There has been severe criticism of this situation, mainly because some men marked essential are well within the draft age and many are under thirty-five. The Manpower Commission has decreed that the medical schools must not be sacrificed under any circumstances. The deans of our two schools have been especially co-operative, and they are constantly re-evaluating the members of their faculties and cutting their numbers to the minimum. With the new three year course in progress it becomes a problem that tasks the ingenuity of all members of their teaching organization. I believe that any member of our medical faculties marked essential should be given the same consideration in the minds of our medical profession as the doctor who is called to the colors. His is an unenviable position. Many members of the faculties have asked me to intercede and have them placed on the available list, many feel that it is unfair to force them to remain at home, and I admire their patriotism, but I also know that they are doing a fine job in their present surroundings.

". . . hospitals Are Expected to Pool Their Resources . . ."

The Community Needs. The doctor who has been found essential so that the people on the home front shall be taken care of equally well as the boys at the front is classified here. It improves the morale of both parties to know that the government is far-seeing enough to realize the importance of adequate medical care at home to the end that an allout war policy shall continue uninterrupted. I now make an appeal for wholehearted co-operation on the part of all hospitals and communities to share with one another whatever is needed to improve the health of our civilian population. In some localities roentgenologists and pathologists are very scarce and some hospitals are unable to secure either a pathologist or a roentgenologist. It is the policy of the Procurement and Assignment Service to arrange to give all of the facilities necessary to aid any and all communities. In a situation as just cited hospitals are expected to pool their resources so as to release some doctors to the armed forces. Furthermore, Procurement and Assignment Service has no power to force you to pool your resources, but we are faced with a duty that shall not be taken lightly. All hospital staffs are to be re-evaluated frequently, and Procurement and Assignment Service will in the future leave no stone unturned to maintain the best possible policy for all the people of this state. The need for physicians by the armed forces is still dire. Dr. Lahey in a radio broadcast said, "We have some 84,000 doctors under forty-five," and Dr. MacIntyre said on the same broadcast, "All physicians under forty-five, physically qualified, should enlist." Up to the present some 40 per cent of all the doctors examined have been disqualified physically. Add to this number 5 per cent who are marked essential, and you will see that practically every doctor up to forty-five will be needed in this allout war.

I might say that at the Council meeting this afternoon, Dr. Phifer of Illinois said that where their quota is something like 4,000, and they have 12,000 physicians to draw from, they have marked available some 2,000, and your quota is 359.

Your committee has marked available some 1,142 doctors, of which 158 are considered essential, throughout the state. In some areas the War Department has informed the chairman of Procurement and Assignment Service that a certain number of doctors, in fact has specifically named the men, were to be marked essential and were to remain in that area until such time as the War Department granted a release. This will no doubt explain the reason for some seemingly unusual situations that have arisen, but it has not been within our province to change an order emanating from that source. With voluminous correspondence to be carried on, long-distance telephone calls interrupting our duties, interviewing individual doctors, it has seemed at times that the day was all too short. At this point may I mention the fact that I am exceedingly grateful to the members of the various committees who have given so generously of their time and effort, and for the splendid co-operation extended to me at all times by Charles Crownhart and other members of the staff of the State Medical Society office.

The following recommendations will be turned over to the Recommendations Committee for deliberation and presentation:

1. All doctors in the state under forty-six be informed, in the several ways possible, that each is being evaluated as to immediate availability as rapidly as possible—to complete a tremendous undertaking self imposed on the medical profession, to secure the over-all picture, and to expedite the clearance of those needed for the national emergency.

2. A pooling of community medical resources for the good of all the people within the community.

3. Stimulation of voluntary enlistment by direct contact with doctors within the draft age.

Committee on Nominations

The next order of business as announced by the speaker was the selection of a Committee on Nominations, and a recess was taken to permit caucus by the delegates from the various councilor districts.

After recess the results of the selections for the Nominating Committee were announced as follows:

District	*Nominee*
First	Dr. R. E. Davies, Waukesha
Second	Dr. T. C. Hemmingsen, Racine
Third	Dr. J. S. Supernaw, Madison
Fourth	Dr. C. A. Armstrong, Prairie du Chien
Fifth	Dr. E. C. Cary, Reedsville
Sixth	Dr. P. R. Minahan, Green Bay
Seventh	Dr. W. M. Trowbridge, Viroqua
Eighth	Dr. A. A. Cantwell, Shawano
Ninth	Dr. E. E. Kidder, Stevens Point
Tenth	Dr. L. O. Simenstad, Osceola
Eleventh	Dr. R. O. Grigsby, Ashland
Twelfth	Dr. W. M. Kearns, Milwaukee
Thirteenth	Dr. W. P. Curran, Antigo

Upon motion by Dr. G. W. Carlson, Appleton, seconded by Dr. E. G. Schneller, Racine, the above personnel of the Committee on Nominations was approved by the House, and the secretary announced provision for the meeting of the committee on the following morning.

Committee on Maternal and Child Welfare

Dr. J. Gurney Taylor, Milwaukee, was called upon by the speaker to present an additional report of his committee, which consisted of discussion of a proposal by the Federal Government to subsidize by specific sums, obstetric and pediatric care for wives and infants of men in the armed services.

Emergency Medical Service

Dr. J. W. Lambert, Antigo, presented a report as assistant state chief of Emergency Medical Service and Field and Casualty Officer.

Dr. Lambert, in presenting a resumé before the House of Delegates, assured the House that if bombs were to fall in strategic areas in Wisconsin, we would find that the medical services would be as efficiently and thoroughly organized as they were when Hawaii was bombed on "Jap Sunday." It was here that the medical profession was found singularly well prepared to care for the civilians injured as the result of enemy action.

In urging still further preparation, Dr. Lambert declared, "The early part of the present war disclosed that the casualties among the civilian population were greater than those among the armed forces. Therefore, it is imperative that the profession in Wisconsin accept its responsibility of leadership in organizing properly its personnel and facilities in our state. Civilian physicians should discharge their duties with the same alacrity and spirit as those physicians who form a part of our armed forces. It is the responsibility of our county chiefs of Emergency Medical Service to assign physicians where, in their judgment, they can render the greatest possible service to the community, and it is the obligation of those physicians so assigned to fulfill that assignment without equivocation."

Subcommittee on Replacements, Committee on War Participation

The speaker then called upon Dr. R. W. Blumenthal to present his report as chairman of the Subcommittee on Replacements. Dr. Blumenthal stated that "Only those who have been deferred on account of physical disability or those beyond the age of forty-five are considered eligible for replacements." In concluding his comments before the House, Dr. Blumenthal advised that "There are certain industries, certain localities, and also certain institutions that have asked for replacements, and a good number of men have been marked 'available when replaced.' In other words, men who are eligible for service will not be permitted to be marked available until someone is there to replace them — someone satisfactory."

Dr. Blumenthal concluded by saying that it was anticipated that definite information would be transmitted to Wisconsin from the regional office of Procurement and Assignment, and that a subsequent announcement would be made.

Committee on Nursing Problems

Dr. W. A. Munn, Janesville, chairman of the Committee on Nursing Problems, submitted the report of his committee emphasizing the scarcity of nurses at the present time and indicated that it was a condition which would constantly become more acute. He outlined the problems which were involved in nursing education that made it difficult to change requirements for nurses' registration due to reciprocity provisions in other states. He also outlined to the House that an increase in the enrollment of nurses' aides would in some measure alleviate the shortage.

He urged the House of Delegates to adopt the committee's recommendation that the delegates of the Society to the American Medical Association collaborate with the Committee on Nursing Problems to the end that a suitable resolution might be prepared and introduced by our delegates urging revision in the curriculum of nursing schools.

Amendments to the Constitution

The speaker asked the secretary to read the amendment to the Constitution proposed by the Council at the 1941 session which, having laid over for one year and having been printed on two separate occasions since that time, was now ready for the vote of the House. Mr. Crownhart read the amendment as follows:

"Amend the Constitution by striking from Article II the phrase reading, 'to guard and foster the material interests of its members and to protect them against imposition.'"

The reasons advanced for striking this portion of Article II were explained by the secretary, the speaker announced that a two-thirds vote of the

House was necessary for adoption, and discussion was called for. There being none, a rising vote was asked, and the amendment was declared adopted without opposition. Reconsideration of the action was requested but failed of second, and the matter was declared closed.

After announcements by the secretary as to time and place of meeting of the various reference committees of the House, functions in connection with the annual meeting and similar matters, the House adjourned until 6:45 p. m. Monday evening, September 14.

MONDAY SESSION

The House of Delegates was called to order by the speaker at 6:45 p. m., Monday evening, September 14, in the Crystal Ballroom of the Hotel Schroeder, this constituting the second session of the House. The report of the Committee on Credentials was read, and a quorum was declared present, after adoption of the report upon motion by Dr. H. H. Christofferson, Colby, seconded by Dr. E. H. Spiegelberg, Boscobel.

Report of Committee on Reports of Officers and Standing Committees

Dr. Irwin Schulz, Milwaukee, chairman of the Committee on Reports of Officers and Standing Committees, presented the recommendation of the committee that the following reports be accepted as published in the September issue of *The Wisconsin Medical Journal* and as orally supplemented at the Sunday evening session: Committee on Cancer, Advisory Committee on Care of Crippled Children, Committee on Hospital Relations, Committee on Maternal and Child Welfare, Council on Scientific Work, Committee on Tuberculosis and Chest Diseases, Committee on W. P. A. Health Projects and the Conference Committee on Open Panels; the report of the Council, the treasurer and the secretary. Upon Dr. Schulz's motion, seconded by Dr. T. C. Hemmingsen, Racine, these reports were accepted.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. A. M. Christofferson, Waupaca, the report of the speaker of the House and the Subcommittee on Civilian Defense of the Committee on War Participation, as given by Dr. J. W. Lambert, were accepted.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. T. C. Hemmingsen, Racine, the report of President-Elect Butler was adopted in its entirety.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. A. M. Christofferson, Waupaca, the report of the Committee on Grievances was adopted.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. J. G. Hoffmann, Hartford, the report of the Committee on Health and Public Instruction was adopted.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. T. C. Hemmingsen, Racine, the report of the Committee on Industrial Health was adopted.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. E. C. Cary, Reedsville, the report of the Committee on Mental Hygiene and Institutional Care was adopted.

Upon motion of Dr. Schulz, for the committee, seconded by Dr. Chester M. Echols, Milwaukee, the report of the Committee on Reports of Officers and Standing Committees was adopted in its entirety.

At this point in the proceedings, the speaker introduced Dr. LeRoy Woodward, president-elect of the Iowa State Medical Society, who addressed the House.

Secretary Crownhart then announced that total registrations for the annual meeting at that hour numbered 1,192 against a registration of 825 at the same time one year previous, such registration including physician members, physician guests, medical students and miscellaneous guests.

Report of Committee on Resolutions and Amendments to Constitution and By-laws

Dr. K. H. Doege, Marshfield, chairman of the Committee on Resolutions and Amendments to Constitution and By-laws, offered the report of that reference committee as follows:

1. The report of the Committee to Study the Medical Practice Act was first brought before the House for action, and motion was made by Dr. Doege, seconded by Dr. R. F. Purtell, Milwaukee, that the report be adopted. After extended discussion by the House, supplemented by remarks by Mr. Manley Brist, counsel for the Minnesota State Medical Association, and Dr. R. G. Arveson, Frederic, an oral vote was taken and the report was declared adopted.

Amendment Regarding Determination of Delegate Representation

2. The following amendment to the By-laws was recommended for adoption by the reference committee:

"Amend Chapter III, Section 2, adding the following paragraph thereto:

"For purposes of this section, the number of fully paid members as of a date thirty days in advance of the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled."

Upon motion of Dr. Doege, for the committee, seconded by Dr. G. W. Carlson, Appleton, the proposed amendment was put to a vote and declared adopted.

Instruction Regarding Date By Which Dues Must Be Paid

3. The reference committee recommended for adoption the suggestion of the Committee on Constitution and By-laws that the secretary be instructed to print in italics in the January, February and March issues of *The Wisconsin Medical Journal* the last sentence of Chapter VIII, Section 1, pertaining to the date by which annual dues must be paid for proper determination of membership.

Upon motion of Dr. Doege that such instruction be ordered, seconded by Dr. Joseph F. Smith, Wausau, this recommendation was adopted by the House.

Amendment Regarding Advising the Secretary Concerning Delegate Representation

4. To clarify further the responsibilities of the secretaries of the county medical societies, the reference committee recommended that the last two sentences of Chapter XI, Section 8 of the By-Laws also be incorporated as a part of Chapter III, Section 2 so that the directory provisions contained in present Chapter XI, Section 8 also shall appear as part of Chapter III, Section 2, thus adding to present Chapter III, Section 2 the following sentences:

"The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions."

Upon motion of Dr. Doege, for the committee, seconded by Dr. R. E. Davies, Waukesha, this amendment was adopted by the House.

Resolutions and New Business

5. Pursuant to a recommendation made to the House of Delegates in 1941 by Dr. James C. Sargent, Milwaukee, in the form of a resolution, it was recommended by the Committee on Reports of Officers and Standing Committees at that session that the following amendment be incorporated in the By-laws of the Society:

"Amend the By-laws of the State Medical Society of Wisconsin creating Chapter III, Section 9, reading:

"Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates."

This matter having been considered at the current session, Dr. Doege moved for the reference committee, seconded by Dr. H. H. Christofferson, Colby, that the amendment be adopted, and the motion carried.

Amendment Regarding Council Meetings During Annual Meeting

6. The reference committee supported a change suggested by the Committee on Constitution and By-laws, that the mandatory meeting of the Council during sessions of the House be dispensed with, in the belief that the Council possesses knowledge of its own responsibilities and duties so that it may meet as necessity demands rather than by command:

"The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require . . ."

Upon motion of Dr. Doege for the committee, seconded by Dr. Chester M. Echols, Milwaukee, the amendment was adopted.

Amendment Regarding Committee on Cancer

7. The Committee on Constitution and By-laws having discovered that while Chapter VII of the By-laws specifies the creation of a Committee on Cancer there is no corresponding section within Chapter VII prescribing its duties and responsibilities, it was the recommendation of that committee, as well as the reference committee, that the present Section 17 be renumbered as Section 18 and a new Section 17 be created to read:

"The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and co-operating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years."

Upon motion of Dr. Doege for the committee, seconded by Dr. W. M. Trowbridge, Viroqua, the amendment was adopted.

Committee on Votuntary Sickness Insurance

8. Dr. Doege moved for the committee that the following amendment to the By-laws be adopted:

"*Resolved that*, Chapter VII, Section 1 of the By-laws be amended by inserting after the title, 'A Committee on Medical Economics,' the additional phrase, 'and Voluntary Sickness Insurance.'

"Section 6 of Chapter VII be repealed, the present committee members discharged with the appreciation of the House of Delegates, and a new Section 6 created to read:

" 'Section 6. The Committee on Medical Economics and Voluntary Sickness Insurance shall be charged with the responsibility of reporting annually to the House of Delegates such recommendations as may, in its judgment, seem proper with reference to the subject of medical economics and voluntary sickness insurance. The committee shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years each.' "

Upon second of Dr. C. J. Weber, Sheboygan, the amendment was adopted.

Amendment to Constitution Regarding Special Dues Classification of Membership

9. The amendment permitting special dues classification as offered in the supplementary report of the Council next came before the House for action. The amendment was as follows:

"Amend Chapter XI, Section 3, by the insertion of a paragraph to read:

" 'By proper provision of Constitution and By-laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the

state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of three years from the date of such election, and shall not be included as a 'fully paid' member as that term is used in Section 2 of Chapter III.' "

Dr. Doege moved for the committee, seconded by Dr. A. R. Tormey, Madison, that the amendment be adopted; carried.

Committee on Interprofessional Relations

10. The recommendation that the Committee on Interprofessional Relations be complimented on its work during the past year and that it be discharged, its duties being taken over by the Committee on Grievances, was presented by Dr. Doege as a motion in behalf of the reference committee, and upon second by Dr. J. S. Supernaw, Madison, was declared adopted.

Committee on Safety on Public Highways

11. Dr. Doege, for the committee, moved adoption of the recommendation that the portion of the report of the Committee on Safety on Public Highways pertaining to legislation providing for mandatory acceptance by courts of chemical tests for determination of intoxication in certain cases, be referred to the Committee on Public Policy for further study. Upon second by Dr. J. F. Smith, Wausau, the recommendation was adopted.

Life Membership

12. The following amendment to the By-laws, as recommended by the Committee on Life Membership, was next brought before the House:

Proposed Amendment to By-law Relating to Dues and Assessments

Resolved, That Chapter VIII, Section 1, of the By-laws of the State Medical Society be amended by striking therefrom in its entirety Paragraph two and substituting the following:

"An active member who shall have attained his eightieth year and shall have been a member of his county medical society in Wisconsin or elsewhere in the United States continuously since beginning the practice of medicine, or who for fiftv years shall have been continuously a member of his county medical society in Wisconsin or elsewhere in the United States, shall, upon establishing the above facts to the satisfaction of his county society, and upon the recommendation of such society, be granted the status of a life member. Such member shall enjoy full membership privileges, and shall be exempt from the payment of further dues or assessments, and a certificate of special membership shall be issued to him annually.

"An active member in good standing in his county society may, upon the recommendation of such society, be granted affiliate membership with full voting and other privileges where one or more of the following conditions exists: retirement from practice; physical or other disability of a character preventing the practice of medicine; a serious and prolonged illness; or financial reverses. Affiliate membership shall be on an annual basis only, and a member must be recommended each year for such special status by the secretary and president of his county medical society following a review and reassessment of his particular situation. An affiliate member shall enjoy full membership privileges and shall be exempt from the payment of dues and assessments during the year in which he is granted such status, and a certificate of membership shall be issued to him for such year.

"An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership."

Dr. Doege moved, for the reference committee, that the above amendment be adopted, and after second by Dr. O. A. Stiennon, Green Bay, it was adopted.

Resolution Regarding Butter

13. The resolution concerning pure dairy butter, as introduced previously by the Committee on Public Policy, was recommended for adoption by the reference committee. After discussion, and upon motion by Dr. K. H. Doege for the committee, seconded by Dr. E. H. Spiegelberg, Boscobel, the resolution was declared adopted by a vote of 34 to 24.

The Procurement and Assignment Service

14. Dr. K. H. Doege moved for the committee that the operation of The Procurement and Assignment Service in Wisconsin be commended and that the recommendations of the state consultant for Wisconsin, Dr. R. E. Fitzgerald, be adopted as set forth on page 1129. Upon second of Dr. R. E. Davies, Waukesha, Dr. Fitzgerald's report was adopted.

1943 Dues

Dr. Doege presented the recommendations of the reference committee concerning the 1943 budget of the Society and dues to be established for the ensuing year, such dues being recommended as $29. With a statement by the speaker that the above recommendations would be re-presented the following morning, Lieutenant Commander William A. Ryan, formerly of Milwaukee and now in the service of the U. S. Navy, was called upon for remarks.

After announcements by the secretary, the House recessed until 8:00 a. m. the following morning, to permit members and guests to attend the annual smoker.

TUESDAY SESSION

The House reconvened at 8:00 a. m., Tuesday morning, September 15, in the Banquet Room of the Hotel Schroeder, this being a continuation of the second session. The report of the Committee on Credentials was presented.

The House, having recessed the previous evening before final action was taken upon portions of the report of the Committee on Resolutions and Amendments to Constitution and By-laws, was addressed by its chairman, Dr. Doege, who again presented the committee's recommendations as to the operating budget for 1943 and dues for that year. Upon motion by Dr. Doege, for the committee, seconded

by Dr. A. G. Hough, Beaver Dam, this portion of the report was adopted, and the 1943 dues were authorized as $29.

After voicing the suggestion of the committee that the outgoing president each year summarize his recommendations to the incoming president, and commending Dr. C. A. Dawson, chairman of the Committee on Public Policy for the work of that committee, Dr. Doege moved that the entire report of the Committee on Resolutions and Amendments to Constitution and By-laws, as amended, be adopted and the committee discharged from further duties at this session. Upon second of Dr. E. C. Cary, Reedsville, the report was declared adopted.

Third Session

There being no further business before the House, upon motion of Dr. F. A. Douglas, La Crosse, variously seconded, the House adjourned, and immediately entered into its third session. The report of the Credentials Committee was accepted as constituting the roll of the third session of the House upon motion of Dr. E. H. Spiegelberg, seconded by Dr. C. J. Weber.

The speaker announced the first order of business, required under the By-laws, as being the report of the Committee on Nominations, and reminded members of the House that nominations by that committee do not necessarily preclude other nominations from the floor.

Election of Officers

Dr. P. R. Minahan, Green Bay, presented the report of the Committee on Nominations in the form of a ticket, as required by the By-laws, containing the name of a nominee for each office, as follows:

For president-elect—Dr. R. M. Kurten, Racine;
For speaker of the House of Delegates—Dr. Charles Fidler, Milwaukee;
For vice-speaker—Dr. P. R. Minahan, Green Bay;
For delegate to the American Medical Association—Dr. S. E. Gavin, Fond du Lac, to succeed himself;
For delegate to the American Medical Association—Lieutenant Commander J. C. Sargent, Milwaukee, to succeed himself;
For alternate delegate to the American Medical Association to succeed Dr. S. J. Seeger, Milwaukee—Dr. L. O. Simenstad, Osceola;
For alternate delegate to the American Medical Association to succeed Dr. F. E. Butler, Menomonie—Dr. A. E. Rector, Appleton.
Place of the 1943 annual meeting—Milwaukee.

There being no further nominations, upon motion by Dr. C. M. Echols, Milwaukee, seconded by Dr. T. C. Hemmingsen, Racine, the secretary was instructed to cast the unanimous ballot of the House for Dr. R. M. Kurten, Racine, as president-elect.

There being no further nominations, upon motion by Dr. E. C. Cary, Reedsville, seconded by Dr. T. C. Hemmingsen, Racine, the secretary was instructed to cast the unanimous ballot of the House for Dr. Charles Fidler, Milwaukee, as speaker.

There being no further nominations, upon motion by Dr. A. G. Hough, Beaver Dam, seconded by Dr. C. J. Weber, Sheboygan, the secretary was instructed to cast the unanimous ballot of the House for Dr. P. R. Minahan, Green Bay, as vice-speaker.

There being no further nominations, upon motion by Dr. W. M. Trowbridge, Viroqua, seconded by Dr. P. R. Minahan, Green Bay, the secretary was instructed to cast the unanimous ballot of the House for Dr. S. E. Gavin, Fond du Lac, as delegate to the American Medical Association to succeed himself.

There being no further nominations, upon motion by Dr. E. H. Spiegelberg, Boscobel, seconded by Dr. C. A. Armstrong, Prairie du Chien, the secretary was instructed to cast the unanimous ballot of the House for Lieutenant Commander J. C. Sargent, Milwaukee, as delegate to the American Medical Association to succeed himself.

There being no further nominations, upon motion by Dr. P. R. Minahan, Green Bay, seconded by Dr. D. J. Twohig, Fond du Lac, the secretary was instructed to cast the unanimous ballot of the House for Dr. L. O. Simenstad, Osceola, as alternate delegate to the American Medical Association to succeed Dr. S. J. Seeger.

In addition to the nomination of Dr. A. E. Rector, Appleton, Dr. W. M. Kearns, Milwaukee, placed in nomination the name of Dr. J. Gurney Taylor for the office of alternate delegate to the American Medical Association to succeed Dr. F. E. Butler, Menomonie. Dr. Taylor's nomination was seconded by Dr. J. C. Griffith, Milwaukee, and the nomination of Dr. Rector was seconded by Dr. E. C. Cary, Reedsville. Upon motion of Dr. R. O. Grigsby, Ashland, seconded by Dr. J. W. Truitt, Milwaukee, nominations were declared closed, and President Gundersen presiding as speaker, appointed Dr. K. H. Doege, Marshfield, Dr. P. R. Minahan, Green Bay, and Dr. J. W. Truitt, Milwaukee, as tellers for the ballot.

Upon report of the tellers to the chair, it was announced that sixty ballots had been cast, of which thirty-eight were for Dr. A. E. Rector and twenty-two for Dr. J. Gurney Taylor. The chair declared Dr. Rector elected, and instructed the secretary so to cast the ballot.

1943 Meeting in Milwaukee

Upon motion of Dr. W. M. Trowbridge, Viroqua, seconded by Dr. G. W. Carlson, Appleton, the place of meeting for the 1943 sessions was designated as Milwaukee; carried.

Introduction of President-Elect Kurten

Dr. R. M. Kurten, Racine, was introduced as president-elect, and addressed the House as follows: "I am proud and happy to have been chosen your president-elect. I recognize the responsibilities of the office and the particularly arduous years that lie ahead of us, but I am certain that with the splendid co-operation of all the members of this

House, the Council, and the Society, we will be able to go along and carry out the traditions of the Society.

"I ask that we continue in the same spirit. We have one objective, and that is to carry Wisconsin medicine to an even higher level, and we hope that will be our only public health objective in the future.

"I thank you for your consideration of me as your president."

Election of Councilors

Dr. G. E. Eck, Lake Mills, placed in nomination the name of Dr. A. G. Hough, Beaver Dam, as councilor for the First District, announcing that the present councilor did not desire to be considered for re-election. There being no further nominations, upon motion of Dr. C. A. Armstrong, Prairie du Chien, seconded by Dr. H. M. Caldwell, Columbus, the secretary was instructed to cast the ballot of the House for Dr. Hough.

Dr. T. C. Hemmingsen, Racine, placed in nomination the name of Dr. C. E. Pechous, Kenosha, to succeed himself as councilor from the Second District. There being no further nominations, upon motion of Dr. T. C. Hemmingsen, seconded by Dr. L. O. Simenstad, Osceola, the secretary was instructed to cast the ballot of the House for Dr. Pechous.

Dr. R. O. Grigsby, Ashland, placed in nomination the name of Dr. T. J. O'Leary, Superior, as councilor for the Eleventh District, to succeed Dr. F. G. Johnson, whose term expires. There being no further nominations, upon motion of Dr. R. O. Grigsby, variously seconded, the secretary was instructed to cast the ballot of the House for Dr. O'Leary.

Dr. J. C. Griffith, Milwaukee, placed in nomination the name of Dr. C. W. Eberbach, Milwaukee, as councilor for the Twelfth District to succeed Dr. H. J. Gramling, Milwaukee, whose term expires. There being no further nominations, upon motion of Dr. C. M. Echols, Milwaukee, seconded by Dr. E. H. Spiegelberg, Boscobel, the secretary was instructed to cast the ballot of the House for Dr. Eberbach.

Dr. J. C. Griffith, Milwaukee, placed in nomination the name of Dr. T. J. Howard, Milwaukee, as councilor for the Twelfth District to succeed Dr. R. E. Fitzgerald, whose term expires. Dr. W. M. Trowbridge, Viroqua, placed in nomination the name of Dr. R. E. Fitzgerald, Milwaukee, to succeed himself. There being no further nominations, nominations were declared closed and the tellers previously appointed conducted the count of the ballots. The chair announced fifty-nine ballots cast, of which thirty-five were for Dr. Fitzgerald and twenty-four for Dr. Howard, and declared Dr. Fitzgerald re-elected to succeed himself as councilor.

Appointments to Standing Committees

The special order of business carried over from the Sunday evening session, relating to committee appointments, was called for. (The complete personnel of the Society's committees will appear in the January issue of *The Wisconsin Medical Journal.*) Committee appointments announced were confirmed.

After announcements by Secretary Crownhart, the chair called upon the new speaker, Dr. Charles Fidler, to adjourn the meeting.

Upon motion of Dr. E. C. Cary, Reedsville, seconded by Dr. C. A. Armstrong, Prairie du Chien, the House of Delegates of the 101st Annual Meeting adjourned, sine die, at 9:20 a. m.

Attendance at House of Delegates, Milwaukee, 1942

Society	*Delegate*	*Sessions* 1	2	3
Ashland–Bayfield–Iron	R. O. Grigsby, Ashland	x	x	x
	C. J. Smiles, Ashland*	a	a	a
Barron–Washburn–Sawyer–Burnett	D. L. Dawson, Rice Lake	a	a	a
	S. O. Lund, Cumberland*	x	x	x
Brown–Kewaunee–Door	P. R. Minahan, Green Bay	x	x	x
	W. W. Kelly, Green Bay*‡	a	a	a
	O. A. Stiennon, Green Bay	x	x	x
	W. E. Leaper, Green Bay*	a	a	a
Calumet	F. P. Knauf, Kiel	a	x	a
	N. J. Knauf, Chilton*	a	a	a
Chippewa	A. J. Somers, Chippewa Falls	x	x	x
	J. J. Sazama, Bloomer*	a	a	a
Clark	M. C. Rosekrans, Neillsville	a	a	a
	H. H. Christofferson, Colby*	x	x	x
Columbia–Marquette–Adams	H. M. Caldwell, Columbus	x	x	x
	L. V. McNamara, Montello*	a	a	a
Crawford	C. A. Armstrong, Prairie du Chien	x	x	x
	H. H. Kleinpell, Prairie du Chien*	a	a	a
Dane	A. R. Tormey, Madison	x	x	a
	S. A. McCormick, Madison*	a	a	a
	H. E. Marsh, Madison	x	x	x
	A. J. Boner, Madison*	x	x	x
	L. R. Cole, Madison	x	x	x
	G. G. Stebbins, Madison*	x	x	x
	J. S. Supernaw, Madison	x	x	x
	C. Vingom, Madison*	a	a	a
Dodge	A. G. Hough, Beaver Dam	x	x	x
	W. E. Bargholtz, Reesevlle*	x	a	a
Douglas	T. J. O'Leary, Superior	x	x	x
	H. J. Orchard, Superior*	a	a	x
Eau Claire–Dunn–Pepin	J. C. Baird, Eau Claire	a	a	a
	R. N. Leasum, Osseo*	x	x	x
Fond du Lac	D. J. Twohig, Fond du Lac	x	x	x
	J. C. Devine, Fond du Lac*	a	a	a
Forest	G. E. Carroll, Laona	a	a	a
	H. C. Marsh, Crandon*	a	x	x
Grant	E. H. Spiegelberg, Boscobel	x	x	x
	J. H. Fowler, Lancaster*	a	a	a

Society	Delegate	Sessions 1	2	3
Green	F. J. Bongiorno, Albany	x	x	x
	L. E. Creasy, Monroe*	a	a	a
Green Lake–Waushara	J. A. Kelly, Green Lake	a	a	a
	H. C. Koch, Berlin*	a	a	a
Iowa	S. B. Marshall, Hollandale	a	x	a
	H. M. Walker, Dodgeville*	a	a	a
Jefferson	G. E. Eck, Lake Mills	x	a	x
	O. F. Dierker, Watertown*	x	a	a
Juneau	C. A. Vogel, Elroy	a	x	a
	A. R. Kaufman, Mauston*	a	a	a
Kenosha	G. C. Schulte, Kenosha	x	a	a
	W. C. Stewart, Kenosha*	a	a	a
La Crosse	F. A. Douglas, La Crosse	x	x	x
	A. H. Gundersen, La Crosse*	a	a	a
Lafayette	W. B. Williams, Argyle	a	a	a
	P. W. Leitzell, Benton*	a	a	a
Langlade	C. E. Zellmer, Antigo	x	x	x
	W. P. Curran, Antigo*	x	x	x
Lincoln	R. G. Baker, Tomahawk	x	x	x
	F. C. Lane, Merrill*	a	a	a
Manitowoc	E. C. Cary, Reedsville	x	x	x
	T. H. Reese, Manitowoc*	a	a	a
Marathon	J. F. Smith, Wausau	x	x	x
	E. E. Flemming, Wausau*	a	x	x
Marinette–Florence	A. T. Nadeau, Marinette	x	x	x
	H. W. Haasl, Peshtigo*	a	a	a
Milwaukee	J. W. Truitt, Milwaukee	x	x	x
	L. J. Van Hecke, Milwaukee*	x	x	a
	E. L. Bernhart, Milwaukee	x	x	x
	H. J. Farrell, Milwaukee*	a	x	x
	J. W. Smith, Milwaukee	x	x	x
	E. J. Carey, Milwaukee	x	x	a
	J. J. Pink, Milwaukee*	x	x	x
	R. A. Toepfer, West Allis	a	a	a
	Aaron Yaffe, Milwaukee*	a	x	x
	J. R. Regan, Milwaukee*	a	x	a
	S. M. Markson, Milwaukee	x	x	x
	G. S. Flaherty, South Milwaukee*	a	x	a
	J. C. Griffith, Milwaukee	x	x	x
	U. E. Gebhard, Milwaukee*	a	a	a
	C. R. Marquardt, Milwaukee	x	x	x
	M. C. Borman, Milwaukee*	a	x	x
	Charles Fidler, Milwaukee	x	x	x
	Irwin Schulz, Milwaukee	x	x	a
	M. W. Sherwood, Milwaukee*	x	a	a
	W. M. Kearns, Milwaukee	x	x	x
	C. M. Echols, Milwaukee	x	x	x
	W. A. Ryan, Milwaukee	x	x	a
	F. X. McCormick, Milwaukee*	a	a	a
	Norbert Enzer, Milwaukee	x	x	a
	C. C. Schneider, Milwaukee*	a	a	a
	R. F. Purtell, Milwaukee	x	x	x
	Benjamin Lieberman, Milwaukee*	a	a	x
	R. E. Galasinski, Milwaukee	x	a	a
	W. L. MacKedon, Milwaukee*	a	a	a
Monroe	C. S. Phalen, Sparta	a	a	a
Oconto	A. F. Slaney, Oconto	a	a	a
	C. R. Kwapy, Oconto*	a	a	a
Oneida–Vilas	W. S. Bump, Rhinelander	x	x	x
	I. E. Schiek, Rhinelander*	a	a	a
Outagamie	G. W. Carlson, Appleton	x	x	x
	D. W. Curtin, Little Chute*	a	a	a
Pierce–St. Croix	Chalmer Davee, River Falls	x	x	x
	O. H. Epley, New Richmond*	x	a	a
Polk	L. O. Simenstad, Osceola	x	x	x
	K. F. Johnson, Frederic*	a	a	a
Portage	E. E. Kidder, Stevens Point	x	x	x
	R. J. Stollenwerk, Stevens Point*	a	a	a
Price–Taylor	J. D. Leahy, Park Falls	x	x	x
	H. B. Norviel, Phillips*	a	a	a
Racine	T. C. Hemmingsen, Racine	x	x	x
	E. J. Schneller, Racine*	x	x	x
Richland	George Parke, Sr., Viola	a	a	a
	G. H. Benson, Richland Center*	a	a	a
Rock	H. E. Kasten, Beloit	x	x	x
	R. A. Thayer, Beloit*	a	a	a
	W. A. Munn, Janesville	x	x	x
	W. T. Clark, Janesville*	x	x	x
Rusk	Woodruff Smith, Ladysmith	a	x	x
	W. F. O'Connor, Ladysmith*	a	a	a
Sauk	A. C. Edwards, Baraboo	a	a	a
	F. R. Winslow, Baraboo*	a	a	a
Shawano	A. A. Cantwell, Shawano	x	x	x
	O. F. Partridge, Mattoon*	a	a	a
Sheboygan	C. J. Weber, Sheboygan	a	x	x
	A. C. Radloff, Plymouth*	x	a	a
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Whitehall	a	a	a
	Robert Krohn, Black River Falls*	x	x	x
Vernon	W. M. Trowbridge, Whitehall	x	x	x
	J. J. Rouse, Hillsboro*	a	a	a
Walworth	E. D. Sorenson, Elkhorn	x	x	a
	D. H. Jeffers, Lake Geneva*	a	a	a
Washington–Ozaukee	J. G. Hoffmann, Hartford	x	x	x
	O. J. Hurth, Cedarburg*	x	a	a
Waukesha	R. E. Davies, Waukesha	x	x	x
	H. T. Barnes, Delafield*	a	a	a
Waupaca	A. M. Christofferson, Waupaca	x	x	x
	J. H. Murphy, Clintonville*	a	a	a
Winnebago	R. A. Jensen, Menasha	a	a	a
	A. G. Koehler, Oshkosh*	x	x	x
Wood	K. H. Doege, Marshfield	x	x	x
	F. X. Pomainville, Wisconsin Rapids*	a	a	a

*—Alternate delegate. x—Present. a—Absent. ‡—Advanced notice of inability to attend.

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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Mrs. W. A. Wagner, Oshkosh

Christmas Greetings, 1942

With the approach of Christmas come kindly thoughts and plans for those we love and those with whom we work.

It is with a deep sense of appreciation for your loyal co-operation that I wish each member of the Woman's Auxiliary to the State Medical Society of Wisconsin a cheerful Christmas, with peace and happiness in the New Year.

This Christmas a loved one may be absent from the family circle, but your sad heart will find comfort in the knowledge that your husband or son is bravely doing his part to protect America's priceless blessings.

In the joy of giving this holiday season, let us remember the lonely hearts of our "Service Wives," for:

"Lighting trees and filling stockings is a way to celebrate Christmas;

"Lighting a heart is the way to feel Christmas."

MRS. E. S. SCHMIDT
President

Program Aims For 1943

By MRS. DONNE F. GOSIN
Program Chairman, Green Bay

A MAJOR problem confronting the Auxiliary today seems to be that of recommending a wartime program that may prove helpful to county units and, after careful planning, adopting a year's program that will include activities suitable for local needs.

Health education is one of the main objectives of the Woman's Auxiliary to the American Medical Association. Let each county unit give special study to local health problems and cooperate with health authorities in eliminating conditions which might be hazards to public health, especially those aggravated by military camps and defense plants.

An all out effort should be made to interest each group in the question of defense nutrition. Members should pledge themselves

COLLEGE OF PHYSICIANS

to food conservation and the study of well balanced diets, consistent with present-day restrictions on certain foods.

Doctors' wives, above all, should be interested in every phase of Red Cross work, particularly courses in first aid and home nursing, and should volunteer as nurses' aides, ready to carry on and be helpful when there is a dearth of doctors and nurses.

Auxiliary groups should keep themselves informed and, through public relations channels, provide meetings and speakers to instruct the laity. At the moment, under the stress of war, programs on mental hygiene would be timely.

Changes in medical legislation, problems of inflation, new developments in medicine, and, above all, what the American doctor is doing to help win the war should be carefully noted.

Excellent speakers for every phase of Auxiliary work are available from the State Medical Society and the State Board of Health. Mrs. Stoddard of Beaver Dam, State Commander of the Women's Field Army for the Control of Cancer, is glad to provide speakers who will present the latest developments in that field.

In the field of self-education, each unit should be familiar with *The Bulletin* and with "Information Please," compiled by the National Auxiliary, and should read and use the valuable material presented in *Hygeia,* the authentic health magazine of the American Medical Association.

"Credo of the Doctor's Wife in Wartime," written by Mrs. William Hibbits, national program chairman, and published in the August *Bulletin,* contains a fund of timely suggestions and ideas.

Your state program chairman urges each group to write freely for help in securing material and suggestions for programs.

Our Women in War Activities

DURING these days of world-wide war, we hear a great deal about the imperative need for leadership and the necessity for action on every front. However, neither soldier nor civilian can follow a leader who has no objective.

True, the Auxiliary to the State Medical Society of Wisconsin has become synonymous with community service. In the past, we have affiliated our efforts with many worthwhile and recognized projects. That, nevertheless, was during a domestic peacetime—now we are at war—and now, more than ever, we need an organized program of effort.

It is not our design to conduct this war, nor to dictate the technics of civilian activities, whether local, state, or otherwise. Our paramount responsibility still rests in community service—and herein there is much we can do.

Foremost, we need goals—objectives formulated from an intelligent examination of the problem at hand—and then, sincere and wholehearted action. To accomplish this purpose our president, Mrs. Schmidt, has appointed a state chairman of War Activities.

Your chairman will presently send out letters to all county presidents, giving them definite information and direction, so that at the close of this year's work we may report 100 per cent participation in this wartime emergency. In addition, you will be urged to keep a record of service hours, to be reported to the state chairman on War Activities.

Therefore, your chairman recommends the following for your individual counties:

1. A thoroughly active membership—herein lies the importance of cooperative effort and unity. Let every member pledge to do her share in this all-out war effort.
2. A comprehensive survey of the abilities and capabilities of each member within every organized unit. This information will give your auxiliary an analysis of personnel and provide, perhaps, the most constructive means of determining future activities.

These are fundamental toward the success of any and all projects that you might at-

tempt. Thereafter, specific action may fall in some of the following directions:

a. In accordance with the resolution passed at the national convention last June, we urge all county auxiliaries "to adopt as one of their chief objectives the promotion of the sale of United States war savings stamps and bonds."
b. To seek and accept leadership in medical defense programs, under the direction of the local medical defense organization.
c. Instruction in home nursing.
d. Nutrition study.
e. Nurses aide courses.
f. Surgical dressing units.
g. Sewing and knitting groups.
h. Canteen service.
i. Blood donor project.
j. Mobile and transportation units.
k. Promotional work in salvage service (scrap metal, rubber, paper).
l. Entertainment for armed service groups.
m. Accident prevention — elimination of home hazards.
n. Health education—panel discussion service.

These are but a few suggested projects. It is the mission of every auxiliary to select its objectives, to formulate the plan, to rally the support, and to meet its responsibilities during this crisis.

All honors to those of you with the courage, the initiative, and the determination to lead the way forward.

Yours for victory,

ARLEEN JOANNES MCCAREY, Green Bay
Chairman, War Activities Committee

Barron—Washburn—Sawyer—Burnett

When members of the Woman's Auxiliary to the Barron–Washburn–Sawyer–Burnett County Medical Society met at the Land O'Lakes Hotel in Rice Lake on November 2, the following officers were elected for the coming year:

President—Mrs. R. W. Adams, Chetek
President-elect—Mrs. S. O. Lund, Cumberland
Secretary–Treasurer—Mrs. D. V. Moen, Shell Lake

Mrs. S. O. Lund, who was a delegate to the state convention, gave a report of the meeting. Following a general discussion of aims and projects, it was decided that the Auxiliary war work now being done in the various communities should be continued.

Dane

Mrs. G. A. Cooper, chairman of publicity for the Woman's Auxiliary to the Dane County Medical Society, reports that new officers elected at the luncheon meeting held at the home of Mrs. W. A. Werrell on September 21 are as follows:

President—Mrs. L. V. Sprague
President-elect—Mrs. F. K. Dean
Secretary—Mrs. W. C. Keettel
Treasurer—Mrs. A. R. Curreri

The chairman of the luncheon, Mrs. H. E. Marsh, was assisted by Mmes. H. M. Carter, G. H. Ewell and F. K. Dean.

Reports on the state convention were given by Mrs. J. S. Supernaw, state past-president, Mrs. T. W. Tormey, Jr., and Mrs. B. I. Brindley. Dr. John K. Shumate, supervisor of Lake View Sanatorium, spoke on "The Understanding Between the Auxiliary and the Sanatorium for Morale."

Seventeen members of the Dane County Auxiliary attended a meeting on October 5 at the home of Mrs. P. A. Duehr, Route 2, Madison. Mrs. Lorna Davies was introduced by Mrs. H. L. Greene, and she discussed Red Cross work, blood bank donorship, and the dayrooms at Truax Field. Members voted to contribute $15 to the Madison War Chest.

Fond du Lac

Mrs. E. S. Schmidt of Green Bay, the new president of the Woman's Auxiliary to the State Medical Society, was a guest of members of the Fond du Lac County Medical Auxiliary on October 22 at the home of Mrs. E. V. Smith, Jr. She discussed civilian medical defense and Red Cross work, urging members to organize and work as a unit in these projects.

Twenty-two members and guests attended this dinner meeting. Assisting hostesses were Mrs. A. M. Hutter and Mrs. J. S. Huebner, both of Fond du Lac.

Kenosha

Members of the Woman's Auxiliary to the Kenosha County Medical Society were entertained by Mrs. A. F. Ruffolo, Kenosha, on November 3. She was assisted by Mrs. H. A. Robinson, Mrs. L. H. Lokvam and Mrs. P. S. Herzog.

It was announced at the business meeting, conducted by Mrs. A. M. Rauch, that work on surgical dressings would be done on Tuesdays instead of Thursdays. A rummage sale, to be held late in November, was planned, and it will be directed by Mrs. Alexander Schlapik, chairman. The members

also voted to co-operate with the bond drive which is being sponsored by all women's organizations.

Following the business meeting, refreshments were served by Mrs. H. A. Robinson and Mrs. G. C. Schulte. Several violin selections were played by Mr. Oswald Lehnert, accompanied by Miss Dorothea Bach.

La Crosse

The La Crosse County Medical Auxiliary held its monthly meeting on the afternoon of October 21 at St. Francis Nurses' Home, La Crosse, the entertainment including a tour of the new building.

Mrs. F. A. Douglas reported for the camp and hospital recreation committee for Camp McCoy, and the Auxiliary voted to help furnish a sunroom. It was also voted to donate to the Christmas gift fund for La Crosse County soldiers. The state convention in Milwaukee was reported by Mrs. E. H. Townsend, and plans were made to entertain the La Crosse County Medical Society sometime in November.

The following committee chairmen were appointed by Mrs. F. H. Wolf, president:

Program—Mmes. J. C. Fox, E. E. Seedorf, J. F. Egan
Social—Mmes. R. C. Johnston, Gunnar Gundersen, Martin Silverton, W. H. Remer
Hygeia—Mmes. P. T. Walters, Louisa Mears, D. S. Smith
Flowers—Mrs. P. C. Gatterdam
Membership—Mrs. W. E. G. Bayley
Public Relations—Mmes. W. J. Jones, R. T. Gray
Philanthropic—Mmes. J. C. Harmon, E. S. Carlsson, F. J. Gallagher
Telephone—Mmes. G. D. Reay, E. J. Schneeberger, R. E. Flynn
History and Archives—Mmes. G. R. Reay, G. W. Lueck
Press and Publicity—Mrs. E. H. Townsend

Milwaukee

The Woman's Auxiliary to the Medical Society of Milwaukee County held a luncheon meeting on October 29 at the Pfister Hotel. Sixty-one members and guests were present.

After calling the meeting to order, Mrs. Harry O. Zurheide, president, introduced Mrs. T. L. Tolan, chairman of the Volunteer Office of the Milwaukee County Council of Defense, and a member of the Milwaukee Auxiliary. She briefly discussed activities at the Blood Plasma Center, canteen duty, nurses' aide work, and general clerical work which is required for all these branches of war work. Mrs. Tolan encouraged members to volunteer for at least one of the services. Mrs. Zurheide mentioned the need for help at the Visiting Nurses Association, and told of classes in home nursing, the making of surgical dressings, and the rolling of cotton.

This meeting took the place of the regular one scheduled for the second Friday in November, because members wished to participate in "Hard of Hearing Week," proclaimed by President Roosevelt for the week of October 25 through 31. Dr. T. L. Tolan, a member of the Medical Society of Milwaukee County and president of the Hard of Hearing Society of Milwaukee County, gave a most interesting talk on the progress made in aid to the deaf.

Dr. Tolan introduced Miss Betty Wright of Washington, D. C., executive director of the American Society for the Hard of Hearing. Her talk was very well received, and was followed by a question and answer period.

Auxiliary members also heard Miss Owens, director of the Paul Binner School for the Hard of Hearing, discuss this subject.

Outagamie

Mrs. E. J. Zeiss, Appleton, assumed the presidency of the Woman's Auxiliary to the Outagamie County Medical Society when it held the first meeting of the fall season on October 29 at the home of Mrs. G. J. Flanagan, Kaukauna. New officers elected are:

President-elect—Mrs. G. W. Carlson, Appleton
Recording secretary — Mrs. E. F. McGrath, Appleton
Treasurer—Mrs. C. D. Neidhold, Appleton

The committee chairmen were announced as follows:

Hygeia—Mrs. F. N. Pansch, Appleton
Archives—Mrs. F. J. Rankin, Appleton
Membership—Mmes. D. M. Gallaher, Appleton; W. H. Towne, Hortonville
Social—Mrs. G. W. Carlson, Appleton
Program and Welfare—Mmes. J. L. Benton, W. J. Frawley, Charles Reineck, Appleton
Public Relations—Mmes. Wallace Marshall, G. J. Flanagan, Appleton
Press and Publicity—Mrs. F. J. Huberty, Appleton
Advisory Council—Mrs. A. C. Taylor, Appleton

Supper was served before the business meeting, with Kaukauna members as hostesses.

Racine

On November 9 some twenty members of the Woman's Auxiliary to the Racine County Medical Society met at the home of Mrs. C. C. Atherton, Union Grove.

Mrs. Herbert G. Brehm of Racine and Mrs. G. J. Schulz of Union Grove spoke on the progress of nutrition classes in their communities, emphasizing the need for day nurseries and school kitchens. Similar reports from the Burlington and Waterford representatives were read by Mrs. C. L. Kline, Racine. The Auxiliary moved to lend its support in obtaining donors for the blood bank sponsored by the Racine County Medical Society. Surgical dressing work furnished by the local hospitals was then distributed by Mrs. W. E. Buckley.

DECEMBER . . . the star of Bethlehem and the bombs of Pearl Harbor . . . the Prince of Peace and the god of war ☆ Christmas will have little meaning to the thousands of physicians who serve their country and perhaps to thousands more who strive to carry on at home. There is little time for exchange of pleasantries in the grim business of winning a war ☆ But the Christmas Season will come again when the forces of evil are dead—when man again will do unto others as he would have done unto him.

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Tea was served by Mrs. Atherton and the assisting hostesses, Mrs. R. W. McCracken and Mrs. G. J. Schulz, both of Union Grove.

Rock

At the annual meeting of the Woman's Auxiliary to the Rock County Medical Society, held on October 27 at the Woman's Club, Janesville, the following officers were elected:

President—Mrs. Thomas J. Snodgrass, Janesville
President-elect—Mrs. G. W. John, Beloit
Secretary—Mrs. W. T. Clark, Janesville
Treasurer—Mrs. O. W. Friske, Beloit

The committee chairmen, all of Janesville, are as follows:

Program—Mrs. G. S. Metcalf
Philanthropic—Mrs. E. C. Hartman
Public Relations—Mrs. R. C. Hartman
Social—Mrs. F. C. Binnewies
Hygeia—Mrs. C. R. Gilbertsen
Telephone—Mrs. W. H. McGuire

Twenty-two members attended this dinner meeting, and Mrs. E. J. Carey, national president-elect, was an honored guest. She gave a resumé of the year's work and outlined the wartime task which lies ahead.

Mrs. Mary Kamps, Janesville, executive secretary of the Rock County chapter of the Red Cross, discussed the work of the Red Cross since Pearl Harbor and appealed to Auxiliary members to volunteer for Red Cross work.

Sheboygan

Recognizing the need for workers to make surgical dressings for the Red Cross, members of the Sheboygan County Medical Auxiliary, meeting on November 4 at the home of Mrs. G. J. Hildebrand, Sheboygan, decided to devote future meetings to this purpose.

Mrs. T. J. Gunther gave a report on medical defense in the city of Sheboygan. Dessert was then served by Mrs. Hildebrand, and bridge was played.

Washington—Ozaukee

Members of the Woman's Auxiliary to the Washington–Ozaukee County Medical Society met at the Mayer Hotel, Port Washington, for a one o'clock luncheon on October 8.

The regular business meeting was then held at the home of Mrs. C. C. Stein, Port Washington, after which bridge was played.

The November meeting of the Washington–Ozaukee County Medical Auxiliary was held on November 12 at the home of Mrs. R. S. Fisher, Allenton. A one o'clock luncheon was served.

The group voted to hold all future meetings at the same time and place as the County Medical Society meetings are held. As its project for the coming year, this Auxiliary will endeavor to place speakers on subjects recommended by the government, particularly nutrition.

Following the business session, four guests joined the members at bridge.

Waupaca—Shawano

The Woman's Auxiliary to the Waupaca–Shawano County Medical Society held a luncheon meeting on November 3 at 1 p. m. at the Elwood Hotel, New London. Thirteen members were present.

In the absence of the president, Mrs. R. Van Schaick of Marion, the business session was conducted by Mrs. W. J. Irvine of Manawa. New officers elected are:

President—Mrs. J. W. Monsted, New London
Secretary—Mrs. H. C. Schmallenberg, New London
Treasurer—Mrs. F. C. Mulvaney, Marion

The subject of future meetings was discussed, and it was decided that as a means of conserving gasoline and tires the Auxiliary should meet on the same day and in the same town in which the medical society convened.

Bridge was played following the business meeting, and prizes were awarded to Mrs. W. J. Irvine, Manawa; Mrs. W. H. Finney and Mrs. Clarence Topp of Clintonville.

THE BULLETIN

Subscriptions to the National Auxiliary publication may be obtained from

Mrs. William A. Wagner
344 Merritt Street
Oshkosh, Wisconsin

or

Central Office, Woman's Auxiliary
43 East Ohio Street, Room 410
Chicago, Illinois

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SOCIETY RECORDS

New Members

N. A. Frankenstein, Madison.
W. R. Marquis, Waunakee.
F. A. Hellebrandt, Madison.
J. G. Van Gemert, Madison.
H. L. Reed, Madison.
M. P. Peters, Madison.

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A. Z. Domine, Madison.
S. K. Wynn, Madison.
J. G. Beck, Sturgeon Bay.
S. M. Roberts, Sparta.
C. R. Dix, Milwaukee.
W. E. Wolcott, Green Bay.
R. C. Brown, Green Bay.
F. E. Schlueter, Milwaukee.
Edward Kiefer, Milwaukee.
G. J. Bergmann, Milwaukee.
W. J. Hanley, Milwaukee.
P. J. Collopy, Milwaukee.
H. T. Schroeder, Wauwatosa.

Changes in Address

Richard Davis, Milton, to 1300 University Avenue, Madison.

M. J. Robertson, Bayfield, to Burbank, California.

F. L. Erdlitz, Peshtigo, to 2031 South Thirty-sixth Street, Milwaukee.

K. P. Hoel, Pewaukee, to 33 Island Avenue, Aurora, Illinois.

Society Proceedings

Barron—Washburn—Sawyer—Burnett

The Barron–Washburn–Sawyer–Burnett County Medical Society held a dinner meeting at the Hotel Land O'Lakes in Rice Lake on November 2. After dinner a motion picture film in color was shown. The subject of the film was the Manchester Operation (Donald–Fothergill Operation for uterine prolapse).

Columbia—Marquette—Adams

At a meeting of the Columbia–Marquette–Adams County Medical Society held at the Raulf Hotel in Portage on November 19, scientific motion pictures on the subject of "Gynecologic Surgery" were shown. Fifteen members were present, and the following officers for 1943 were elected:

President-elect — Dr. Edward F. Tierney, Portage
Alternate delegate—Dr. Edward F. Tierney, Portage
Secretary–Treasurer—Dr. John H. Houghton, Wisconsin Dells

Dane

The Dane County Medical Society held its monthly meeting at the Madison club at 8:00 p. m., November 10. Speaker at the meeting was Dr. John E. Gonce, Jr., who discussed "Tetanus Toxoid Immunization."

Dodge

A meeting of the Dodge County Medical Society was held at the famous Red's Tavern in Juneau on October 29 at 8:00 p. m. There was no speaker. Election of officers was held, and the following doctors were elected:

President—Dr. George H. Hoyer, Beaver Dam
Vice-president — Dr. Peter F. Langenfeld, Theresa
Secretary—Dr. Harold J. Heath, Juneau
Delegate—Dr. William E. Bargholtz, Reeseville
Alternate-delegate—Dr. Francis G. Bachhuber, Mayville
Censor—Dr. George G. Drescher, Horicon

Douglas

Eighteen members of the Douglas County Medical Society met on October 7 at the Hotel Superior, Superior, to elect officers for 1943. The following, all of Superior, were elected:

President—Dr. Henry A. Sincock
Vice-president—Dr. Elmer A. Myers
Secretary–Treasurer—Dr. Milton Finn
Censor—Dr. James W. McGill
Delegate—Dr. James W. McGill

At its November 4 meeting, the Douglas County Medical Society heard Dr. Samuel S. Houkom, Duluth, speak on "Bunions."

Eau Claire—Dunn—Pepin

The Eau Claire–Dunn–Pepin County Medical Society met on October 26 at the Hotel Eau Claire to hear Dr. Rudolph P. Gingrass, Milwaukee, discuss "Infections of the Head and Neck," and Dr. Marcell E. Gabor, Milwaukee, speak on "Bowel Obstruction." Forty members were present and the following officers elected:

President—Dr. Clarence H. Falstad, Eau Claire
Vice-president—Dr. Francis A. La Breck, Eau Claire
Secretary—Dr. Roland A. Buckley, Eau Claire
Delegate—Dr. Ben F. Johnson, Mondovi
Alternate-delegate—Dr. Walton R. Manz, Eau Claire

Fond du Lac

On October 22 the Fond du Lac County Medical Society met at the Retlaw Hotel, Fond du Lac, and elected the following officers, all of Fond du Lac, for 1943:

President—Dr. Karl K. Borsack
Vice-President—Dr. Stephen A. Theisen
Secretary–Treasurer—Dr. Philip J. Clark
Delegate—Dr. David J. Twohig, Sr.
Alternate-delegate—Dr. David N. Walters
Censor—Dr. Linwood C. Gardner

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At the November 19 meeting of the Fond du Lac County Medical Society, B. J. Secor, U. S. Navy, spoke on his recent adventures in the Pacific theatre of war.

Jefferson

The Jefferson County Medical Society met at the Forest Lawn Sanatorium on November 19 at 6:30 p. m., to hear Dr. Anthony V. Cadden, Wauwatosa, speak on "Results of Collapse in Treatment of Pulmonary Tuberculosis." Dr. R. P. Yohn, Superintendent of the Muirdale Sanatorium, Milwaukee, discussed Dr. Cadden's address.

Kenosha

At a meeting of the Kenosha County Medical Society held at the Elks Club, Kenosha, on October 22, a dinner was given in honor of Dr. Walter C. Kleinpell, Kenosha, who was recently commissioned in the U. S. Navy, and left the following day to take up his training assignment. Dr. Joseph P. Graves, Kenosha, was appointed to fill out the term of Dr. Kleinpell as secretary of the society.

Marinette—Florence and Menominee

A joint meeting of the Marinette–Florence and Menominee County Medical Societies was held at the Marinette County Hospital on November 18 at 6:30 p. m. Dr. Marcos Fernan–Nunez of Marquette University presented motion pictures on "Spirochaeta."

Racine

The Racine County Medical Society met at 8:00 p. m. on November 19 at the Racine Country Club to elect officers and consider applications for membership. At 8:30 p. m., Dr. C. W. Muehlberger, Michigan State Board of Health, spoke on "Scientific Methods of Crime Detection."

Sheboygan

Fifteen members of the Sheboygan County Medical Society gathered on November 12 at the Sheboygan Memorial Hospital to hear Dr. John D. Steele, Milwaukee, speak on "The Indications for Bronchoscopy with Special Reference to Carcinoma." The following officers were elected at this meeting:

President—Dr. Calvin M. Yoran, Plymouth
Vice-president—Dr. Leslie W. Tasche, Sheboygan
Secretary–Treasurer — Dr. William G. Huibregtse, Sheboygan
Censor—Dr. Wesley W. Van Zanten, Sheboygan
Delegate—Dr. Carl J. Weber, Sheboygan
Alternate-delegate—Dr. Alfred C. Radloff, Plymouth

Trempealeau—Jackson—Buffalo

At its annual meeting to elect officers, the Trempealeau–Jackson–Buffalo County Medical Society, meeting in Arcadia on November 19, elected the following:

President—Dr. Max O. Bachhuber, Alma
President-elect—Dr. Kenneth F. Manz, Black River Falls
Secretary–Treasurer—Dr. Richard L. Alvarez, Galesville
Delegate—Dr. R. L. MacCornack, Whitehall
Alternate-delegate—Dr. Robert Krohn, Black River Falls
Censor—Dr. Emmet A. Meili, Cochrane

Winnebago

The Winnebago County Medical Society gathered at the Mercy Hospital, Oshkosh, at 8:00 p. m., November 5, to hear Dr. Alexander D. Spooner, Milwaukee, speak on "Diagnostic Problems in Urologic Disease." The meeting was followed by a dutch luncheon and social hour.

Ninth Councilor District

The autumn meeting of the Ninth Councilor District Medical Society was held at the Hotel Wausau, Wausau, on the afternoon and evening of November 12. Beginning at 4:00 p. m., a clinical pathologic conference was held, at which time a number of interesting case histories were reviewed and discussed by members and the speaker. Following the conference, dinner was served at the Hotel Wausau. After dinner, Dr. Norbert Enzer, Clinical Pathologist, Mount Sinai Hospital, Milwaukee, discussed "The Influence of the Central Nervous System on Fatigue and Disease."

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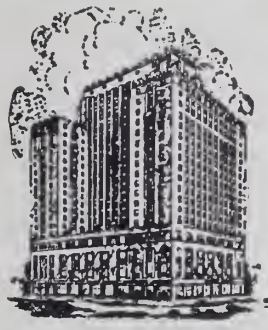

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News Items and Personals

At a Manitowoc county health officers' organization meeting held at the Brita center in Manitowoc November 5, and presided over by *Dr. Valentine A. Gudex*, district health officer from Fond du Lac, *Dr. Erwin C. Cary*, Reedsville, was named president.

Addresses were the following: "Tuberculosis," *Dr. John M. Kelley*, medical director of Maplecrest Sanatorium at Whitelaw; "Duties of Health Officers," *Dr. A. P. Zlatnik*, city health officer of Two Rivers; "Relation of the Medical Men to the Health Officers," *Dr. Charles E. Wall*, city health officer of Manitowoc; "The Public Health Nurse in Relation to the Health Officer," Miss Gertrude Clouse, district advisory nurse of Fond du Lac.

—△—

Dr. George T. Hegner, Appleton, spoke on "Americanism" at the monthly meeting of the Holy Name society of St. Mary's Catholic church, Appleton, on November 8.

—△—

Dr. Madeline J. Thornton, associate professor in the department of obstetrics and gynecology at the University of Wisconsin Medical School, was honored at the fall luncheon of the University League on October 21.

Dr. Thornton, who has published outstanding research articles in the clinical application of endocrinology, is a member of the American Board of Obstetrics and Gynecology and the American College of Surgeons.

—△—

Dr. Gustav J. Hildebrand, Sheboygan, presided over a meeting of Southeastern and Lake Shore health officers held in Milwaukee, October 22. *Dr. Fred B. Welch*, head of the Janesville health department, was in attendance. The business of the meeting concerned a study of cleaner and better milk supplies.

—△—

Dr. Joseph C. Springberg, practicing physician and surgeon in Beloit during the last six years, was named city health officer at the regular meeting of the city council on November 2. He succeeds *Dr. Richard A. Thayer*, who is now in service with the armed forces.

Dr. Springberg's appointment was made by City Manager A. D. Telfer and was confirmed by unanimous vote of the council.

—△—

Dr. William J. Carson, Milwaukee, has been elected president of the American Interprofessional Institute at a convention held in St. Paul, Minnesota.

—△—

New health and sanitation problems were discussed on November 4 by some fifty Rock county health officers, representatives of the State Board of Health and others interested in health problems, at a meeting held in the Janesville court house.

Dr. Henry M. Guilford of the State Board of Health's bureau of communicable diseases led a discussion of the health officers' duties in checking the spread of communicable diseases and pointed out the need for diphtheria immunization and small pox vaccination programs.

—△—

Dr. Garfield M. La Croix, Shiocton, has been appointed health officer for the village of Black Creek.

—△—

Dr. Carlyle R. Pearson, Baraboo, has been elected to fellowship in the American College of Surgeons.

—△—

Ft. Atkinson's Memorial Hospital, completely remodeled and made thoroughly modern and efficient by the installation of new equipment, held open house for the public on November 8. The hospital now has facilities to care for 20 patients.

—△—

The Committee on Postgraduate Education of the Medical Society of Milwaukee County presented a course of postgraduate teaching covering the gastrointestinal tract at the Marquette University School of Medicine on November 2, 3, 4.

—△—

Dr. Samuel G. Higgins, Milwaukee, *Dr. Aubrey H. Pember*, Janesville, Dr. Ralph H. Woods, La Salle, Illinois, and Mr. Austin B. Belgard, Chicago, Illinois, gave an intensive course in Refraction, Physiologic Optics and Practical Optics at the Pember–Nuzum Clinic in Janesville, December 6 through 11.

—△—

Dr. Francis D. Murphy, Milwaukee, and *Dr. Alvin G. Koehler*, Oshkosh, arranged the program presented to the Wisconsin Heart Association at its December 4 meeting held at the Milwaukee County Hospital.

—△—

At a staff meeting of the Wisconsin General Hospital on November 17, Dr. Theodore C. Erickson spoke on "Head Injuries." On December 1 *Dr. Frederick A. Davis* spoke on "Common Pathologic Conditions of the Fundus of the Eye."

—△—

The Wisconsin Academy of Surgery met on December 3 at the University Club in Milwaukee. Dr. Louis G. Hermann, associate professor of surgery at the University of Cincinnati, spoke on "The Surgery of Blood Vessels," and *Dr. Karl Schlaepfer*, Milwaukee, discussed "Anisocoria in Chronic Appendicitis."

BIRTHS

ANNOUNCEMENT

Delayed Dispatch

"In line with the President's request for increased production, the Dr. O. F. Foseid Corporation announces the launching of its first experimental product, namely the S. S. Michael Reid.

"The ceremony took place Saturday, October 17, 1942, at 10:06 p. m., at the Neenah, Wisconsin docks of the Theda Clark hospital. Dr. J. P. Canavan and Dr. W. B. Hildebrand severed the ropes as the tiny craft slid down the runway, hind side first into the sea of life. (There was no time to think of cracking a champagne bottle.) Its sleek lines are streamlined, but built for power, greatly resembling the father ship. At time of delivery it grossed 7 lbs. 8 ozs. Temporarily the mother ship is confined to dry dock for necessary repairs.

"The keel of the little destroyer was laid last January in Tennessee and transported to the Neenah yards for completion. If the experiment proves satisfactory, the corporation expects to launch several more of the same design in the future."

A son to Dr. and Mrs. Milton Finn, Superior, on November 11.

A daughter, Patricia Fern, to Dr. and Mrs. Robert E. McDonald, Milwaukee, on October 22.

A daughter to Dr. and Mrs. Silas M. Evans, Milwaukee, on November 9.

A daughter, Diane, to Dr. and Mrs. Benjamin J. Malnekoff, Milwaukee, on September 19.

A son to Dr. and Mrs. Louis V. McNamara, Montello, on September 25.

MARRIAGES

Lieutenant Irving I. Cowan, U. S. Navy, and Miss Joan Clarice Reydman, Milwaukee, on October 30 at San Diego, California.

DEATHS

Dr. Clarence A. Kelly, 33, St. Croix Falls, was accidentally killed while hunting deer on November 16. Another hunter, mistaking him for a deer, shot him in the back, and death was instantaneous.

Dr. Kelly was born in St. Paul, Minnesota in 1909. He received his medical education at the Marquette University School of Medicine, and practiced medicine in St. Croix Falls for five years before his death.

Dr. Kelly was a member of the Polk County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, a daughter, his parents, two brothers and one sister.

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Dr. Sergius A. Hartman, 70, Milwaukee, died at his home on November 13 after a three months' illness.

He was born in Russia, and practiced for twelve years in Chicago after first coming to this country. He then moved to Milwaukee, where he had been practicing for forty-five years.

He is survived by his widow and one son.

Dr. Deo C. Munger, 79, Ellsworth, died on October 24 after an illness of several years' duration.

He was born in Goodhue county, Minnesota in 1863. He received his medical education at Rush Medical College and began practice in Maiden Rock. In 1897 he moved to Ellsworth where he maintained offices for forty years.

Dr. Munger was a former member of the Pierce County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, one son, a daughter and a sister.

Dr. Julius F. Mauermann, 70, Monroe, died on October 23 at Orangeville, Illinois. He had been ill for two years.

He attended the University of Wisconsin, where he played football with the famous Pat O'Dea in 1898. He was a loyal follower of the Wisconsin team all of his life. Dr. Mauermann completed his medical education at the Northwestern University Medical School in 1903.

Dr. Mauermann was a former member of the Green County Medical Society and of the American Medical Association. He was made a life member of the State Medical Society of Wisconsin in 1941.

He is survived by his widow, two sons, a daughter and a sister.

Dr. David T. Jones, 82, Wausau, died on October 20 at his home. He had been actively engaged in his medical practice until about a year ago, when he was forced to retire because of ill health.

Dr. Jones was born in Racine in 1860. He attended the Oshkosh normal school, and after graduation taught in the Chilton high school. Here he served his preceptorship in medicine under the direction of the late Dr. David La Count. He later attended the College of Physicians and Surgeons in Chicago, from which he was graduated in 1888. He was a preceptor for the University of Wisconsin Medical School, a capacity he filled for many years.

He was a member of the Marathon County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, a son, Dr. Merritt L. Jones, Wausau, and two brothers.

Dr. W. E. Fairfield, 80, Green Bay, died on October 18 at his home after an illness of about a year.

Born in Canada, Dr. Fairfield studied medicine at McGill university, Toronto. At the age of twenty-six, he came to Wisconsin in an endeavor to improve his failing health. He took up practice in Wequiock, and during late years recalled with satisfaction that he was told he had not long to live when he came to this state from Canada.

He was a former member of the Brown–Kewaunee–Door County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, one son, and a brother.

Coming Events

Wisconsin General Hospital Staff Meetings For 1942–43

These meetings are held in the Auditorium of the Service Memorial Institute. Attendance is restricted to third and fourth year medical students, internes, residents, hospital and medical school faculty, and interested outside physicians.

December 15—Dr. W. M. Nesbit: Common Office Procedure in the Practice of Ear, Nose, and Throat
January 5—Dr. C. M. Kurtz: Cardiac Problems for the General Practitioner
January 19—Dr. W. H. Oatway and associates: Symposium on Tuberculosis
January 26—Dr. R. E. Burns: Backache
February 2—Dr. E. L. Sevringhaus: The Rudiments of Managing Diabetes and Obesity
February 16—Dr. L. W. Paul: Fundamentals of Gastro-Intestinal X-ray Diagnosis
February 23—Dr. E. R. Schmidt: Problems of Abdominal Surgery
March 2—Dr. I. R. Sisk: The Etiology and Treatment of Renal and Ureteral Stones
March 16—Dr. J. E. Gonce: Some Aspects of Urinary Infection in Infancy and Childhood
March 23—Dr. C. S. Harper: Office Gynecology
April 6—Dr. R. E. Campbell: Carcinoma of the Uterus
April 20—Dr. K. L. Puestow: Sigmoldoscopic and Radiologic Correlation in Diagnosis and Treatment of Colonic Disorders

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April 27—Dr. O. O. Meyer: Peripheral Vascular Disease
May 4—Dr. E. A. Pohle: Indications and Contraindications for Roentgen Therapy

Milwaukee Children's Hospital Clinical Presentations

The staff of the Milwaukee Children's hospital will offer the following clinical presentations during the month of December:

December 11—Pediatric Clinic
December 14—Surgical Clinic
December 15—Orthopaedic Clinic
December 18—Clinicopathologic Conference

The time of the presentations will be from 12:30 to 1:30 p. m. Dr. Arthur A. Schaefer will direct the surgical clinic, Dr. Walter P. Blount will direct the orthopaedic clinic, and Dr. A. L. Kastner will direct the pediatric clinic.

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Mr. C. H. Crownhart
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If desired, physicians may obtain this booklet directly from Mead Johnson and Company at Evansville, Indiana.

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** Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60

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